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February 1961

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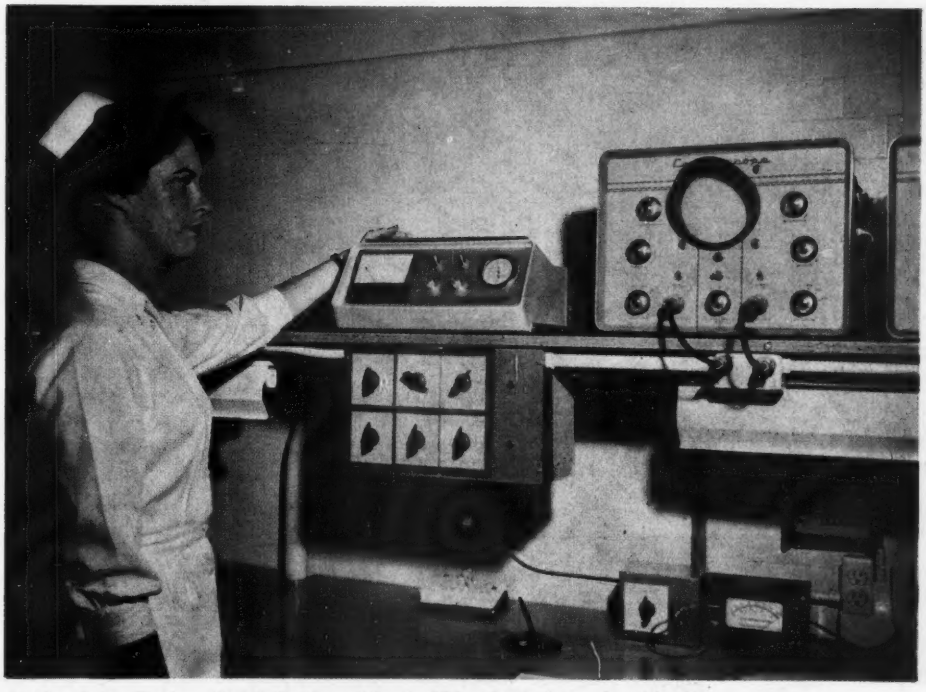
HOSPITAL Management

THE JOURNAL FOR ADMINISTRATORS AND DEPARTMENT HEADS



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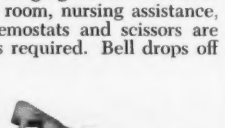

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Fatigue — Factors Involved

by Ernest W. Fair

■ "DOES THAT TIRED feeling come over you every afternoon even though there's still hours to go? Do you feel like throwing up your hands and calling it a day when there are still a lot of things which must be done? Then take ——."

We'll cut off the patent medicine spiel at this point. Patent medicines designed as "pepper uppers" may have their place and certainly a lot of business men get a lift out of them BUT there are many other ways to cut down fatigue in one's day.

The readiest system would be to cut one's work in half but there is hardly a hospital executive in the land who can follow such procedure and survive the dissection.

Our other alternative is to make some adjustments in our business routine which can reduce the fatigue connected with the job.

Here are some steps taken by a number of executives whose routines we have studied in order to discover how they have eliminated the fatigue problem in their own jobs.

Misuse of the Eyes

That's one of the most prevelant causes of fatigue. Many executives found that where they had been careful to provide proper lighting for their associates, it had been completely neglected in their own personal use on those parts of their jobs where required.

Note that the word is "misuse" and not "overuse." The latter is supposed to be the most common cause of such fatigue. Optometrists who have a large clientele of business men point out that while both causes of fatigue exist the man with the latter is much more apt to do something about it than the one with the former.

Where it is fairly obvious such misuse is helping to bring on fatigue it can often be corrected by better and more uniform illumination in our own office and when we plan this we should consider the whole visual field of the area in which we work and not just the desk top.

Taking Rest Periods During the Day

Many executives were made aware of the value of this procedure when they followed the example of their staff and took "coffee breaks" along with that staff.

They found that a policy of several additional "rest breaks" if for no more than five or ten minutes at a time materially helped reduce their own personal problem of fatigue.

Fatigue is always brought on by built-up nervous tensions and the effects these have on our whole physical being. If we can keep nervous tension from building up during the day we reduce the possibility of fatigue. One way many executives do this is to take those frequent rest periods . . . either at regular intervals or whenever they feel such tension building up.

Pace Yourself

"One day, tired and exhausted, I was looking out of my office window and started thinking about my college days as an athlete," one executive told us in suggesting this point, "and I remembered how my coach used to keep hammering away at us that we had to learn to pace ourselves properly to keep alert and fight fatigue.

"It worked for me then at athletics so why shouldn't I apply it in my business life? Then and there I

decided to try it and doing so has kept me up to standard all through the day ever since."

Learning to pace oneself is a hard task. It takes a lot of planning of the business day at the start; afterwards such pace setting will come almost automatically, we have been told.

"Develop a personal schedule chart," is advice offered from several business men who are today never troubled with the fatigue problem and are accomplishing more than ever before.

Practically all of one's business chores can be anticipated although the exact details usually remain hidden. Every business man knows that he must give so much time to this chore, so much to that and a given amount to one of many others during any day. These can all be set up on a schedule.

The first such chart will merely serve to tabulate the schedule. From this we can then re-arrange such tasks so that particularly trying ones do not follow each other, without "breathers" between the strenuous jobs. Several executives found, with such an analysis, that some of these chores could also be combined with one another. A number discovered that they were doing chores which could as well be handled by subordinates and adding needlessly to their daily work load.

Break up Dull Routines

Fatigue comes from driving, hard work under pressure. It also comes from hour after hour application to dull, but necessary, routines. Too many successive hours of such routines can break the mental and physical stamina of any business man. Breaking up such dull routines with lighter, less exacting or more pleasant chores will help to reduce fatigue from this source.

Watch those working positions. Another frequent cause of executive fatigue (and most often overlooked) is our working in cramped or restricted positions. Such situations exact a terrific toll on any individual's muscles during only a few hours at a stretch. Added up over an entire day they can be most damaging.

Working at a poorly designed desk, a mis-matched chair and desk, on a desk or chair of improper height, with poorly placed arm rests on one's work chair, etc., are just a few specific examples. With these in mind we can make a thorough check up of our own individual working area and probably discover several others which add to our fatigue problem.

Improper work clothes should be avoided. A lot has been written about comfortable working clothes for the men in the factory, people in stores and working girls in offices, but very little has been done to appraise the executive that he too must wear proper working clothes.

Ill fitting or tight shoes, to cite one example, can really pile fatigue on a business man's shoulders. A too tight belt around the waist, the wrong sized under garments, etc., can each do it's part toward making our average work day an unpleasant one.

Watch that body temperature. That's important too . . . when we work under the right body temperature fatigue has less chance to build up. Still air in our working space is our greatest enemy in this respect for it interferes with the normal regulation of body temperature.

Proper Nourishment

Restaurant men tell us that the average business man gives less attention to securing proper nourishment for his day's work than the average girl who works in an office. The executive body must have its proteins, calories, etc., for proper fueling during the day; if it fails to receive them "that tired feeling" comes about long before mid-afternoon.

"You can work too long and too much," a number of executives told us," and when you forget it you're not only asking for an extra load of fatigue to carry but you are invariably shortening your life span as well.

"There are limits to what any one man can do and how long a period of time in a given day he can devote to his work. The quicker any man recognizes this the sooner he will become a better executive than he is today."

There are other factors such as working under nerve wracking noise conditions, working with too much emotional tension, etc., which we can avoid in our program of reducing fatigue in connection with our own jobs. All are worth searching out so that we can either be rid of them or take corrective steps to reduce their effect.

Fatigue always defeats any business man's doing his job properly. The tired business man is invariably an inefficient executive. ■

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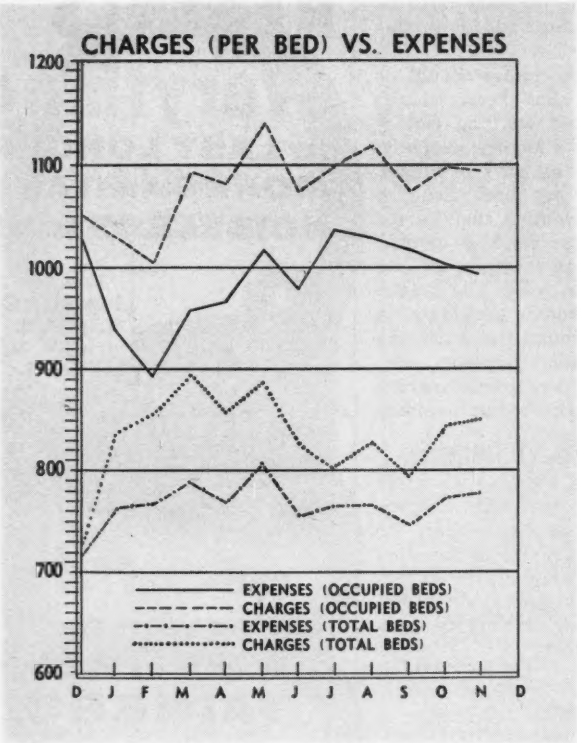


how's business? (See also page 12)

■ THERE WAS A TIME when endowment income was an important item in the hospital budget. Evidence shows that its importance is fast dwindling.

Specifically we inquired about classification of endowments which provide for a free room or other free facilities for certain classes of individuals to be supported out of the endowment income.

Twenty percent of our sample replied that they have no endowments at all; 20% reported no endowments falling into this category; 25% considered the income unrestricted as to use and 35% classified the income as restricted to a specific use.

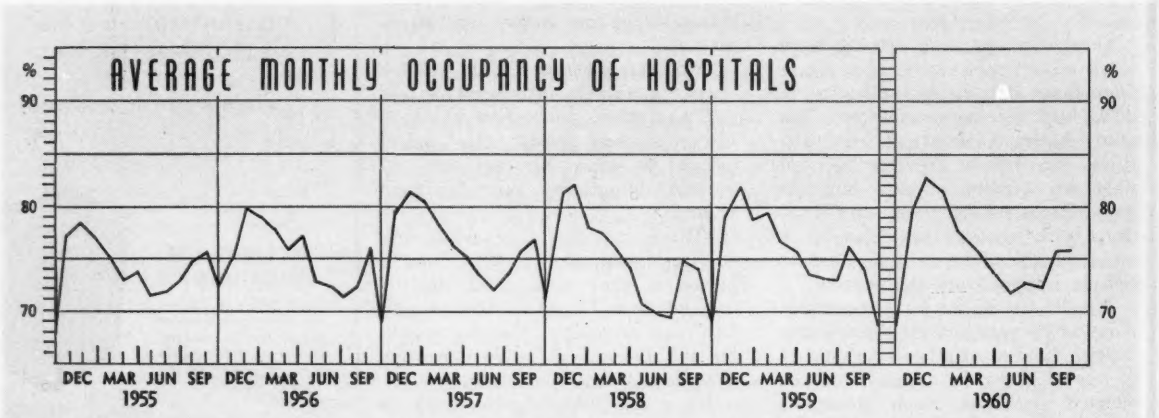
Evidently there is a great need for standardization in endowment accounting. ■

Average Monthly Occupancy (on 100 percent basis)

August, 1959	72.92
September, 1959	72.70
October, 1959	75.89
November, 1959	74.04
December, 1959	68.47
January, 1960	79.79
February, 1960	**82.98**
March, 1960	80.12
April, 1960	77.46
May, 1960	75.69
June, 1960	**73.70**
July, 1960	71.87
August, 1960	72.65
September, 1960	72.18
October, 1960	75.52
November, 1960	**75.54**

Average Length of Patient Stay (in days)

May, 1960	6.8
June, 1960	**6.5**
July, 1960	6.9
August, 1960	6.5
September, 1960	6.8
October, 1960	6.9
November, 1960	**7.0**



Average Operating Expenses Per Occupied Bed Per Month

October, 1959	973.05
November, 1959	943.55
December, 1959	1024.35
January, 1960	931.61
February, 1960	892.14
March, 1960	958.97
April, 1960	965.96
May, 1960	**1026.69**
June, 1960	**977.48**
July, 1960	1034.11
August, 1960	1025.95
September, 1960	1001.85
October, 1960	1001.05
November, 1960	**993.48**

Average Patient Charges Per Occupied Bed Per Month

October, 1959	1065.30
November, 1959	1017.72
December, 1959	1049.82
January, 1960	1029.94
February, 1960	1004.78
March, 1960	1093.36
April, 1960	1081.27
May, 1960	**1137.90**
June, 1960	**1075.49**
July, 1960	1099.81
August, 1960	1114.64
September, 1960	1071.61
October, 1960	1097.03
November, 1960	**1095.98**

Average Operating Expenses Per Bed Per Month (Total Beds)

October, 1959	750.63
November, 1959	721.54
December, 1959	719.74
January, 1960	761.09
February, 1960	764.44
March, 1960	789.87
April, 1960	768.31
May, 1960	**800.81**
June, 1960	**753.68**
July, 1960	760.35
August, 1960	763.53
September, 1960	745.63
October, 1960	771.08
November, 1960	**776.40**

Average Patient Charge Per Bed Per Month (Total Beds)

October, 1959	818.07
November, 1959	775.11
December, 1959	729.25
January, 1960	835.22
February, 1960	853.91
March, 1960	895.38
April, 1960	855.00
May, 1960	**886.94**
June, 1960	**824.03**
July, 1960	800.13
August, 1960	826.63
September, 1960	792.80
October, 1960	844.26
November, 1960	**849.61**

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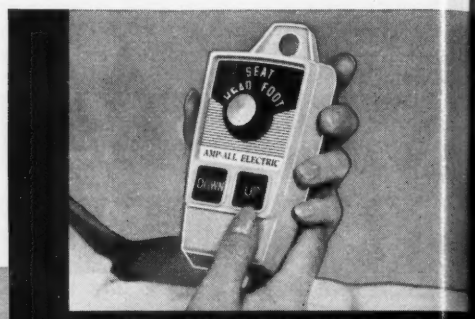

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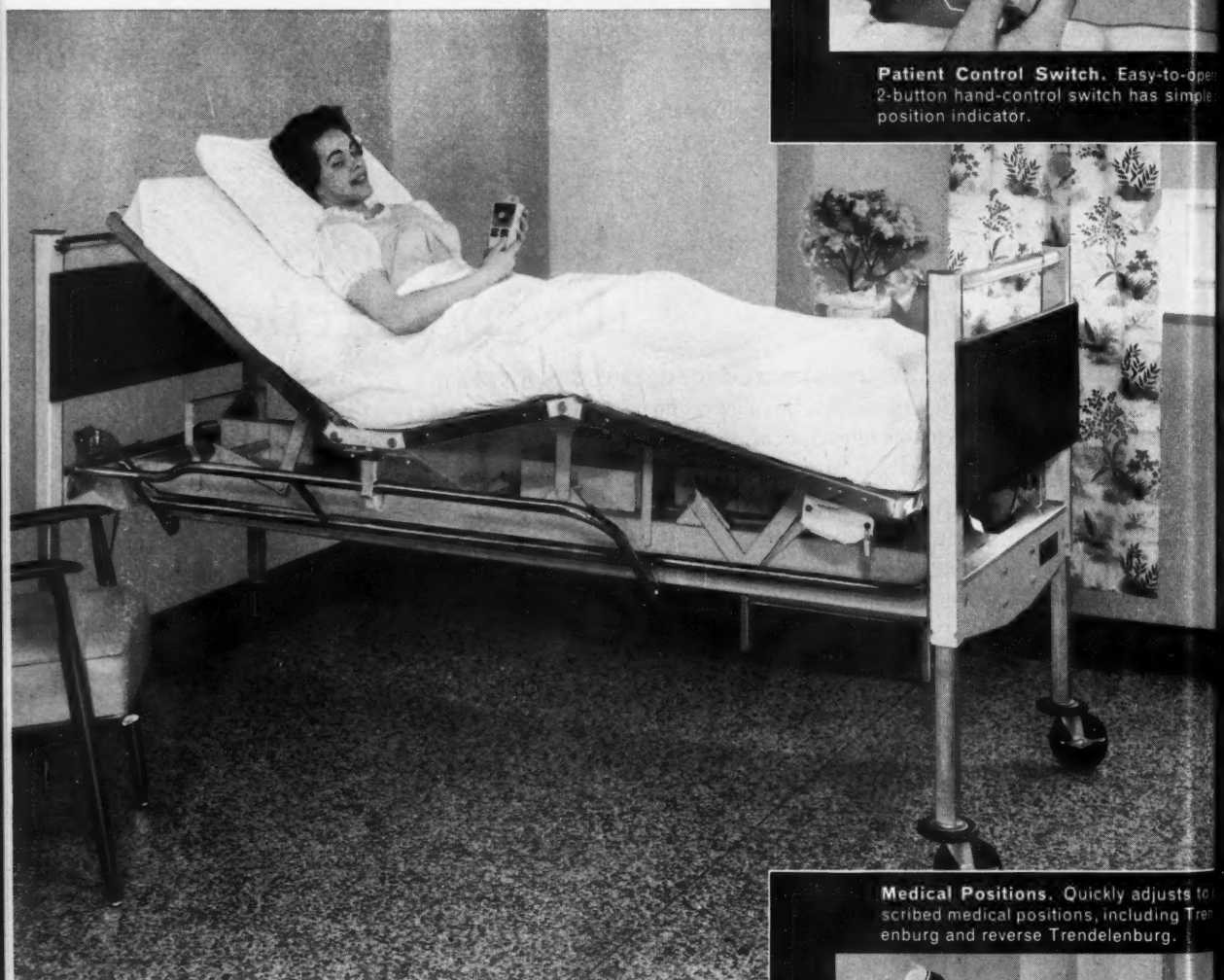

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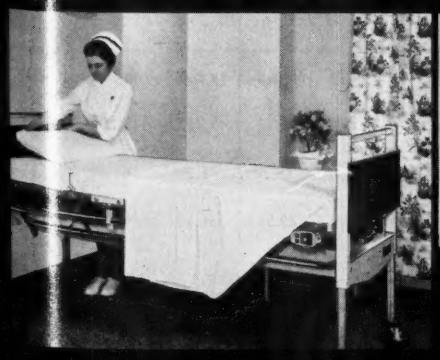

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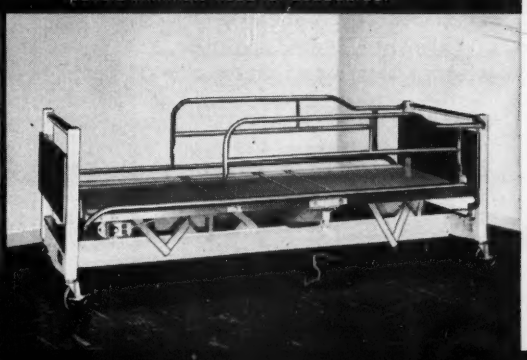
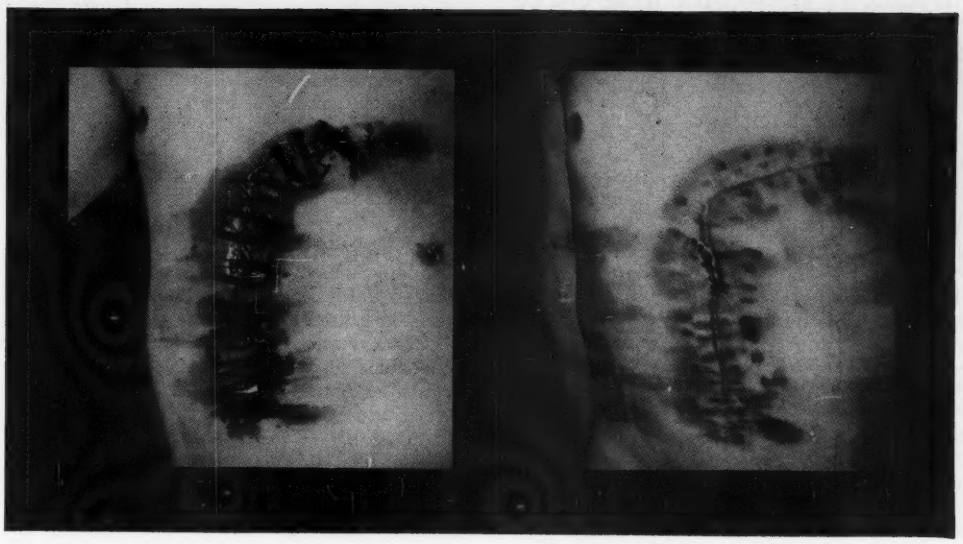


November 1960 Regional How's Business Report

REGION →	NEW ENGLAND Connecticut, Maine, Mass., N. H., R. I., Vermont			MIDDLE ATLANTIC New Jersey, New York Pennsylvania			SOUTH ATLANTIC Del., Fla., Ga., Md., N. C., S. C., Va., W. Va., D. C.			SOUTH CENTRAL Ala., Ky., Miss., Tenn., Ark., La., Okla., Texas		
NO. OF BEDS	1-100	101-225	226-up	1-100	101-225	226-up	1-100	101-225	226-up	1-100	101-225	226-up
AV. No. OF ADULT PATIENT DAYS	1,264	4,205	8,995	1,091	4,096	10,610	1,341	3,388	9,883	1,214	3,662	6,754
% of OCCUPANCY	69.50	85.53	86.47	68.07	79.78	86.57	66.20	78.09	82.05	67.37	75.09	74.25
EXPENSES BY DEPTS. Per Patient Day												
Administration	3.93	4.79	4.54	4.08	3.26	3.35	3.34	4.13	3.24	4.46	3.79	4.93
Dietary	4.34	4.43	4.66	3.53	3.63	3.90	3.41	3.93	3.24	3.46	3.80	3.92
Housekeeping	1.51	1.75	1.95	1.45	1.35	1.55	1.20	1.26	1.26	1.40	1.18	1.34
Laundry	.80	.72	.70	.69	.65	.56	.58	.79	.62	.68	.58	.60
Plant Operation	1.86	2.23	2.40	2.59	1.97	2.03	1.87	1.93	1.71	2.13	1.77	2.16
Medical & Surgical	.70	1.76	1.99	1.51	1.23	1.86	1.25	1.61	2.15	2.65	1.39	2.28
O. R. & Del. Rms.	1.34	2.45	2.18	1.84	1.39	1.83	1.46	2.12	2.43	2.22	2.98	2.89
Pharmacy	1.72	1.52	1.47	1.02	1.28	1.27	1.70	1.71	1.56	1.73	2.36	2.37
Nursing	8.89	8.65	7.56	8.28	7.53	7.11	6.51	7.22	7.15	7.28	7.64	8.17
Anesthesia	.15	.52	1.00	1.06	.52	.86	.40	.49	.47	.77	.43	.68
Laboratory	1.36	2.65	2.90	1.64	1.95	2.24	1.54	1.91	2.30	2.83	2.52	2.90
X-ray	1.69	1.69	2.13	1.61	1.63	1.31	1.70	1.44	1.53	1.64	1.72	1.91
Other expenses	.63	.98	2.33	.79	1.07	1.56	.77	.72	1.64	.89	.72	1.36
TOTAL EXPENSES	36,280	147,186	334,261	31,246	113,709	318,380	33,538	101,721	296,584	37,146	116,249	243,522
TOTAL CHARGES TO PATIENTS	39,204	163,069	357,624	31,109	129,090	404,077	34,856	110,390	328,714	40,290	128,895	262,172
OPERATING INCOME PER PATIENT DAY	31.02	38.78	39.76	28.51	31.52	38.08	25.99	32.58	33.26	33.19	35.20	38.59
OPERATING EXPENSES PER PATIENT DAY	28.70	35.00	37.16	28.64	27.76	30.01	25.01	30.02	30.01	30.60	31.74	35.84

REGION →	EAST NORTH CENTRAL Illinois, Indiana, Michigan, Ohio, Wisconsin			WEST NORTH CENTRAL Kans., Iowa, Minn., Neb., N. D., S. D., Mo.			MOUNTAIN STATES Ariz., Colo., Idaho, Mont., Nev., N. M., Utah, Wyo.			PACIFIC COAST California, Oregon, Washington		
NO. OF BEDS	1-100	101-225	226-up	1-100	101-225	226-up	1-100	101-225	226-up	1-100	101-225	226-up
AV. No. OF ADULT PATIENT DAYS	1,308	3,547	8,642	945	3,127	8,608	1,284	3,323	6,094	1,054	3,934	7,278
% of OCCUPANCY	68.90	76.29	91.10	63.90	74.65	81.03	75.50	71.47	81.04	56.34	77.33	76.39
EXPENSES BY DEPTS. Per Patient Day												
Administration	3.88	3.85	4.23	2.85	3.02	3.62	4.18	5.19	2.56	7.54	5.74	4.97
Dietary	3.55	3.89	3.89	2.98	3.53	3.98	3.84	3.73	3.46	5.12	3.69	4.76
Housekeeping	1.30	1.72	1.43	.99	1.18	1.70	1.24	1.61	1.24	1.91	2.04	2.36
Laundry	.75	.78	.63	.78	.69	.66	1.03	.86	.73	1.08	1.12	1.05
Plant Operation	2.01	2.30	2.18	1.79	1.96	2.16	3.02	2.22	1.67	2.92	2.58	2.42
Medical & Surgical	1.59	1.44	1.92	1.58	3.02	2.42	2.26	1.08	1.66	2.72	2.30	5.73
O. R. & Del. Rms.	1.71	2.16	2.18	1.27	1.94	2.49	1.89	2.46	2.30	4.32	3.10	3.24
Pharmacy	1.47	1.57	1.61	1.54	1.56	1.68	2.56	1.82	1.79	2.30	1.45	1.64
Nursing	8.57	8.57	7.90	7.47	6.71	6.42	8.96	10.69	8.91	12.76	11.37	9.19
Anesthesia	.64	.71	.47	.51	.47	.42	.87	1.09	.60	.78	.88	.90
Laboratory	1.76	2.55	2.19	1.55	1.74	2.67	2.11	3.00	2.64	3.06	2.91	3.15
X-ray	2.01	2.19	1.85	1.29	1.48	1.66	2.22	2.31	1.77	3.19	2.47	2.15
Other expenses	.44	.46	1.15	.54	.79	1.68	.38	.57	.81	.53	3.52	2.28
TOTAL EXPENSES	37,767	114,495	277,357	22,619	88,478	272,724	39,690	120,422	180,058	48,868	166,388	315,774
TOTAL CHARGES TO PATIENTS	40,207	121,129	307,233	23,191	91,500	293,763	45,816	126,502	215,597	49,265	163,204	336,713
OPERATING INCOME PER PATIENT DAY	30.74	34.15	35.55	24.54	29.26	34.13	35.68	38.07	35.38	46.74	41.48	46.26
OPERATING EXPENSES PER PATIENT DAY	28.87	32.28	32.09	23.94	28.29	31.68	30.91	36.24	29.55	46.36	42.29	43.39



Mixed bacterial infection of wound following closure of dehisced laparotomy incision. Infection persisted despite intensive local and systemic therapy.

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Postoperative wounds: fight infection, facilitate healing

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Washington Bureau Reports

Walter N. Clissold

James D. Snyder

CHANCES ARE GOOD that the new Congress will pass depreciation laws that would allow faster writeoffs and full recovery on costs of capital equipment. On the other hand, there's a strong threat of a new tax. The Department of Labor wants Congress to include non-profit organizations under federal unemployment insurance laws. Profit-making enterprises are now covered in each state, paying a tax roughly equal to 3% of each employee's first $3,000 in wages. The 3% is used by each state to pay unemployment benefits to workers laid off through no fault of their own. Passage of this proposal again depends upon how much success Congressional liberals are enjoying. However, they are certain to meet vociferous arguments that non-profit hospitals cannot withstand another increase in costs.

AHA MAY HAVE A TOUGH TIME convincing Congress that hospitals are making full use of the Federal College Housing Loan program. Last year Congress increased from $50 to $100 million the amount available to hospitals to construct housing for student nurses, interns, and residents. It also raised the maximum for a single loan from $500,000 to $750,000. Yet to date, less than half of the $100 million has been used, and in 23 states no hospitals have applied. Due to the relative lack of interest shown there is now strong pressure to divert much of the hospital loan fund to construction of badly needed dorms for college undergraduates. The College Housing Loan program is run by the Community Facilities Administration at the Housing and Home Finance Agency. Maximum maturity on loans in 40 years at about 3½% interest.

HOSPITAL PHARMACISTS NOTE: A Federal Grand Jury has indicted the Northern California Pharmaceutical Association on charges of fixing retail drug prices so as to be "high, arbitrary, and noncompetitive." The U.S. Justice Department alleges that the chairman of the association's pricing committee has since 1956 sold "price charts" to retail druggists, who follow them closely. Justice Dept. is also prosecuting this case to test whether or not it has jurisdiction over retail pharmacies as interstate businesses. The prosecution argues that the retailers are "interstate" because they sell drugs produced in other states. Justice Department lawyers are also winding up pretrial hearings in a similar price fixing case against three Arizona pharmaceutical associations.

NEW DRUG REGULATIONS, effective January 8, state that drug promotional material sent to physicians must list all possible hazards as well as the sterling qualities. The order also rules that prescription drug labels must identify lot or control numbers in order to determine the manufacturing history. Senator Estes Kefauver (D-Tenn.) "commended" FDA's efforts toward tighter drug control, but said his Senate drug hearings are going right on anyhow with sights set on even tougher legislation. Kefauver's biggest slap at drug makers to date is a bill to break up rigid patent controls over new wonder drugs. The Senator feels that because companies are allowed exclusive 17-year patents on any new life-saving drugs they develop, drug prices are kept too high. Breaking up the patent laws would spur competition and lower prices.

NURSING HOMES received a harsh appraisal by the Senate Subcommittee on Problems of the Aged. Following a study on nursing homes, the Subcommittee reported: there is an acute national shortage of about 127,000 nursing home beds. 50% of the existing 307,681 beds are "unacceptable according to Hill-Burton standards." Very few nursing homes have rehabilitation or restorative services. Only one-third of skilled nursing homes have a registered nurse or licensed practical nurse. The Subcommittee recommended that: 1) federal nursing home standards be established; 2) federal aid be increased to nursing homes.

DOCTORS EMPLOYED BY HOSPITALS may deduct the cost of malpractice insurance. Internal Revenue Service has ruled that while an employee may usually not deduct personal expenses such as insurance premiums, doctors working for hospitals are just as liable in malpractice lawsuits as private physicians, and may therefore deduct this cost as a necessary business expense.

PRESIDENT KENNEDY is definitely serious about setting up a Cabinet-level Department of Urban Affairs. However, at this writing no one at the White House seemed to know what existing agencies it would engulf, except for the Housing and Home Finance Agency. The new department could well bring in transportation planning bodies as well as agencies on water and air pollution, which are now square pegs at HEW. All health agencies, no matter how "urban," would probably be left within HEW.

FEDERAL COMMUNICATIONS COMMISSION has licensed 30 Veterans Administration hospitals to operate a shortwave amateur radio network. VA uses shortwave radio in manual arts therapy, patient rehabilitation, and for emergency communications during disaster periods.

SENATOR HUBERT HUMPHREY (D-Minn.) has urged the new Administration to expand the "Atoms for Health" program in 1961. As chairman of a subcommittee studying international medical research, Senator Humphrey pointed out that although the Atomic Energy Commission spent $2.4 billion dollars in fiscal 1959, less than 2% went for medical research.

PEOPLE: President Kennedy has named *Boisfeullet Jones,* 47, as special assistant for Health and Medical Affairs at HEW. The new top medical advisor has been in charge of health services at Atlanta's Emory University and a leader in national hospital affairs . . . . *Dr. J. Lowell Orbison* has begun a four year term on the Pathology Training Committee at NIH . . . . Public Health nursing leaders *Edna J. Brandt* and *Margaret B. Dolan* have been appointed to three year terms on the Expert Advisory Committee for the Professional Nurse Traineeship Program at PHS.

Lehn & Fink
PROFESSIONAL DIVISION

staph newsletter

TENTH OF A SERIES WITH SIGNIFICANT SUGGESTIONS FOR CONTROLLING CROSS INFECTIONS

HERE it is the season again to be on the alert against spread of flu and flu-like illnesses which, all too frequently, lead to staphylococcal pneumonia and death in high-risk patients. Although the influenza epidemic wave of the first three months of 1960 was not as severe as the Asian-flu winter of 1957-1958, the USPHS still considers that it caused 26,000 excess deaths during the period. Of these, 80% were in patients over 65 years old and 90% were attributable either to pneumonia-influenza or complications of renocardiovascular diseases. Unlike many viruses, the influenza virus can and does persist for days in virulent form in the environment unless destroyed by intensive disinfection measures.

Last month, when we first told you about our new Amphyl® Spray Disinfectant and Deodorant, we were so intent on its convenience and effectiveness as a spot disinfectant and air deodorant that we forgot to mention one of its very good features. This is that it does not leave an oily or sticky residue. To demonstrate this, one of our technical representatives applies Amphyl Spray to his white shirt cuff! For surfaces, you can demonstrate it on a glass door or mirror—but why not spray it right on to a door handle or bed side table where it can go to work as the disinfectant it is? Would you like our descriptive folder and bacteriologic reports on Amphyl Spray? If so, please write us.

"Staphylococcal enteritis or staphylococcal diarrhea among our hospitalized patients is a source of concern to us, since we do not know its exact relation to potentially fatal pseudomembranous enterocolitis, to the possible role of intestinal staphylococci in serving as a reservoir for staphylococcic infection of other patients in our hospitals, or to the transfer of these intestinal organisms to other parts of the body where their presence may present serious problems, such as wound infections, pneumonia and septicemia."

Drs. Dearing and Needham of the Mayo Clinic and Mayo Foundation made the above comments after a two-year study of 243 consecutive, hospitalized patients whose stool cultures revealed the presence of Staph. aureus. (J.A.M.A., Nov. 19, 1960) Although none of the seven stated purposes of this study was evaluation of the extreme dangers of cross infection, awareness of this potential is evident throughout the report.

In the care of such patients, aseptic housekeeping measures are essential to help avoid autoinfection of the patient, spread of organisms to other patients, and infections of personnel. Thorough disinfection of floors and equipment, as well as linens and blankets, is dependably accomplished with any one of the L&F refined phenolic disinfectants—Amphyl®, O-syl®, and Lysol® disinfectants or Tergisyl®, our detergent-disinfectant. As you know, all are widely microbicidal, including staphylocidal, pseudomonacidal, tuberculocidal and fungicidal. Specific recommendations for using each product are available for individual or group instruction. If you need multiple copies for teaching purposes, just let us know. We'll be glad to send them.

If you're wondering whether it's still important for a disinfectant to be a tuberculocide, consider this statistic from the Virginia Public Health Department. In the years 1957 to 1959, 42% of the tuberculous individuals who died were first identified as such on the death certificate.

Many long-range reports now being published confirm that, in most hospitals, staph infection exists at an endemic level. Goal of contamination control measures is to lower that level and to prevent emergence of epidemics or, should they occur, to curtail them quickly. Isolating patients admitted with staph infections, as well as those developing staph infections after admission, is now widely recommended. Frequently, the success of such units in preventing spread of infectious organisms throughout the hospital depends upon specific and dependable disinfection procedures within the isolation unit. *Use of Amphyl® on floors, walls, furniture and fixtures and in laundering blankets, linens, and curtains will destroy these offending organisms. Our new literature covers specific instructions for Amphyl disinfection of isolated units. Bacteriologic data is, of course, included. May we send it to you?*

℞ for eliminating staphylococci from 50 blankets: add 1 gallon of Amphyl® to 100 gallons of water, rotate for 3 minutes, soak for 10 minutes, add soap or detergent and follow usual washing procedure. If residual antibacterial effect is desired, add 1% Amphyl to last rinse.

If there's any doubt in your mind about the basic role that bactericidal floor cleaning can play in infection control, please write us for a reprint of the article "The Floor As A Reservoir Of Hospital Infections", by Carl W. Walter, M.D., and Ruth B. Kundsin, Ph.D., as published in Surgery, Gynecology & Obstetrics, October, 1960. Graphic comparisons are made between bacterial counts when floor disinfection is done at 30-day intervals and 24-hour intervals. The difference is significant.

Have you a baffling contamination control problem in your hospital on which we might help? Although we realize that disinfection is only one part of the complete control program, as you know, it is an important one. Our research laboratories and technical advisers are ready to help and I, personally, would like very much to hear from you.

Charles F. Manz
General Sales Manager
Professional Division

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with Doctor Letourneau

Traffic Fines

QUESTION: *We have limited parking space around the hospital and on several occasions I have been forced to leave my car in no parking zones. Doctors do this but do not get ticketed. But because I am an administrator, I have paid several parking tickets during the past year. May I deduct this from my income tax?*

ANSWER: Traffic fines are definitely not deductible.

Preadmission Forms

QUESTION: *Several of our preadmission forms are made up in the doctor's office including consent to surgery and we are wondering if this is a proper practice.*

ANSWER: It is quite proper for the patient to sign an operation consent before admission provided that this is done in reasonable time before the operation is to take place.

Emergency Service

QUESTION: *Since we no longer have interns because of the new rule regarding foreigners, we have had a great deal of difficulty in staffing our emergency department. Recently, the medical staff recommended that doctors over the age of 40 should not be required to take emergency calls. Unfortunately, there are only nine doctors under this age and three of them live about 15 miles from the hospital. They feel that this is an imposition and asked me to get your opinion.*

ANSWER: Where there are no residents, interns, externs or full-time personnel to take emergency calls, every physician who is on the active staff should take his turn until he is retired. Anyone who feels too old, too weak, too tired, or too infirm to take emergency calls should be promoted to the honorary staff where he will have no duties and also no privileges. It should be remembered that hospital privileges also carry with them hospital duties.

Infection Committee

QUESTION: *Recently, the physician who is chairman of the infection control committee spied an operating room nurse in green cap and gown leaving the dining room to return to the surgical operating room. He reported her to the administration and demanded that she be relieved of her duties for breach of technique. He was told to mind his own business because the local nurse association had not yet accepted this practice as a breach of technique. The nurses in the hospital threatened to walk out if this nurse was punished. What should the adminstrator do?*

ANSWER: In any hospital, the care of the patient takes rank and precedence over the prerogatives of doctors, nurses and of anyone else. Since the rule in question was established for the protection of the patients, the chairman of the infection committee was within his rights in reporting this matter to the administration. The administration should enforce whatever sanction is called for in a breach of technique of this kind but sanctions should be thought out before they are enforced.

Responsibility of Anesthetist

QUESTION: *We have had an altercation concerning who should give an anesthetic. We have been told that giving anesthetics is the practice of medicine and so no one but a licensed physician should give an anesthetic. On the other hand, anesthesiologists themselves refuse to work after 5:00 p.m. and tell us that after this time nurse anesthetists should be used for maternity cases and emergency surgery. This does not make any sense to us and we would like to have your opinion.*

ANSWER: This does not make any sense to me either. I have never been able to understand why the giving of anesthetics is the practice of medicine from 8:00 a.m. to 5:00 p.m. but then becomes the practice of nursing from 5:00 p.m. to 8:00 a.m. Perhaps the American Society of Anesthesiologists might be able to resolve this question at some future time.

Surgical Control Committee

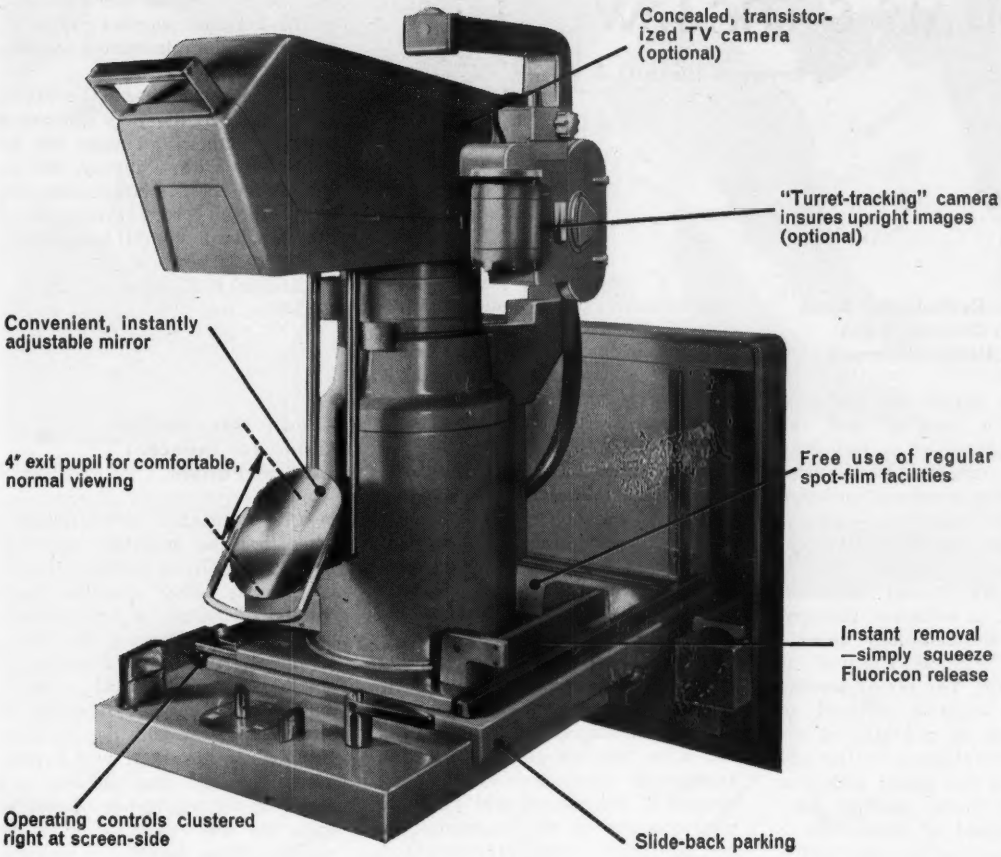
QUESTION: *What qualifications are required of the chairman of the surgical control committee?*

ANSWER: He should start off by being a qualified surgeon who is in a position to judge the quality of surgery in others. He should have some experience in the hospital and should be familiar with the work of his colleagues who do surgery. He should be honest, conscientious and fearless in expressing his opinion, being swayed neither by fear nor by favor.

Malpractice Insurance

Question: *I am a hospital administrator and during the past year my board has urged me to take malpractice insurance in the event that I should be sued for malpractice while doing my job. Several attorneys and friends have told me that this is an unnecessary expense as an administrator cannot commit malpractice. What is your advice?*

ANSWER: Several administrators have been sued as a result of accidents happening in a hospital. To my certain knowledge no hospital administrator has ever been convicted of administrative negligence but there is a first time for everything and you would probably not want to gain fame in this manner. It is better to carry the insurance; the premiums are relatively low. ■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hospitals & the law

by Emanuel Hayt, LL.B.

Hospital and Radiologist Sued for Failure to Disclose Risks of Cobalt Radiation Therapy

■ THIS IS AN ACTION for malpractice against a hospital and the physician in charge of its radiology department to recover for injuries sustained as the result of radiation therapy with radioactive cobalt, alleged to have been given in an excessive amount.

Dr. Kline, a licensed physician and specialist in radiation therapy, was head of the radiology department at St. Francis Hospital at Witchita Kansas. The plaintiff seeks damages for injuries claimed to have sustained as a result of alleged acts of negligence in the administration of the cobalt radiation treatment. Dr. Kline and the hospital were named as defendants.

The case was tried to a jury which returned a verdict in favor of both defendants.

Dr. Kline's assistant was a hospital employee by the name of Darter who determined by necessary computations how to administer the desired quantity of radiation, ordered by Dr. Kline, by means of a moving beam.

The evidence upon which the appellant relies is that the radioactive cobalt beam was delivered at an angle to the chest wall in an effort to avoid injury to the lungs. In making the calculations to achieve the tumor doses (one and one-half to two centimeters deep), the equilibrium doses (five millimeters deep) were not calculated by Darter.

We are here concerned with a case where the physician is charged with treating the patient without consent on the ground the patient was not fully informed of the nature of the treatment or its consequences, and, therefore, any "consent" obtained was ineffective.

The appellant knew she had a cancerous tumor in her left breast which was removed by a radical mastectomy. Pathological examination of the tissue removed did not disclose any spread of the cancer cells into the lymphatics beyond the cancerous tumor itself. As a precautionary measure the appellant's ovaries and fallopian tubes were removed, which likewise upon pathological examination indicated no spread of the cancer to these organs. At the time the appellant went to Dr. Kline as a patient there was no immediate emergency concerning the administration of cobalt irradiation treatment such as would excuse the physician from making a reasonable disclosure to the patient. We think upon all the facts and circumstances here presented Dr. Kline was obligated to make a reasonable disclosure to the appellant of the nature and probable consequences of the suggested or recommended cobalt irradiation treatment, and he was also obligated to make a reasonable disclosure of the dangers within his knowledge which were incident to, or possible in, the treatment he proposed to administer.

These facts are not commonly known and a patient cannot be expected to know the hazards or the danger of radiation from radioactive cobalt unless the patient is informed by a radiologist who knows the dangers of injury from cobalt irradiation. While Dr. Kline did not testify that the radiation he gave the appellant caused her injury, he did state cobalt irradiation could cause the injury which the appellant did sustain.

"On retrial of this case the first issue for the jury to determine should be whether the administration of cobalt irradiation treatment was given with the informed consent of the patient, and if it was not, the physician who failed in his legal obligations is guilty of malpractice no matter how skillfully the treatment may have been administered, and the jury should determine the damages arising from the cobalt irradiation treatment. If the jury should find an informed consent was given by the patient for such treatment, the jury should next determine whether proper skill was used in administering the treatment.

"In the instant case the instructions given to the jury did not define the issues and state the pertinent law with accuracy, and further instructions were requested. By reason of the errors heretofore noted the appellant should be granted a new trial."

(Natanson v. Kline et al., 350 P. 2d 1093-Kan.)

County Hospital Not Liable for Indecent Acts on Patient

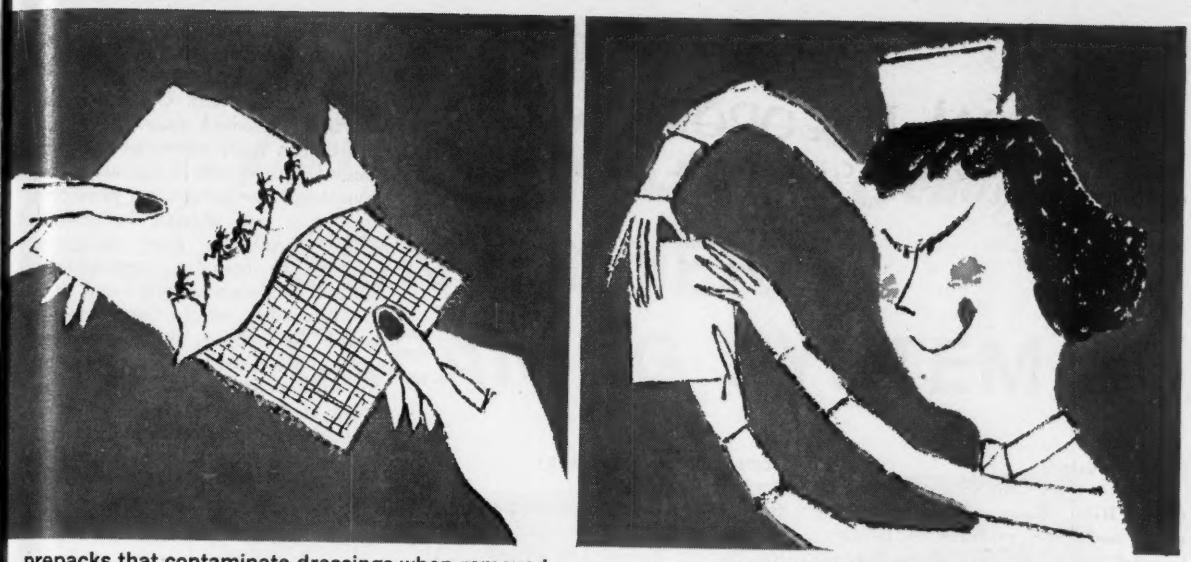
■ THE COMPLAINT in substance alleges that the appellant was a patient in the Glenn General Hospital, which was being operated by the county of Glenn, a subdivision of the state of California; that the respondent Albert O. Pugatch was employed by, and acted as the superintendent of, said hospital; that on or about the 29th day of March, 1958, while appellant was a paying patient in said hospital, and as the result of the negligence of respondents, she was examined by a male person, whose identity is unknown, who then and there committed unlawful, indecent and lewd acts upon the person of appellant, which thereby caused the injuries and damages as alleged in her complaint. It is further alleged that said hospital was not "engaged" in a purely governmental activity.

In the instant case the complaint does not allege that Pugatch committed any wrongful act causing personal injury to appellant. It merely alleges that he negligently failed to take precautions to prevent unauthorized persons from entering the rooms of patients.

The cases have uniformly held that county hospitals are exercising governmental functions and that the counties are not liable for the negligence of employees toward patients therein. The imposition of a charge is not inconsistent with the exercise of a governmental function where the activity is one for public health and safety. County hospitals fall within such classification.

Dismissal of the complaint was affirmed on appeal.

(Ingram v. County of Glenn 11 CCH Neg. Cases 2d 55-Cal.) ■



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*T.M.

MEDICAL RECORDS

by Adeline C. Hayden, C.R.L.

Interval History

***QUESTION*: Many of our patients come back for readmission to the hospital within 30 days of discharge. We realize that an interval history may be taken and used in such instances but just how detailed should this interval history be?**

ANSWER: The interval history should carry the usual identifying information carried on all forms, any changes in conditions and family status since last hospitalization, present complaint, any changes in physical findings since last admission and the provisional diagnosis for the current admission.

Medical Records Bibliography

***QUESTION*: I would like a good Medical Records Bibliography. Is one available?**

ANSWER: There is an annual publication. Write the Catholic Hospital Association, St. Louis, Mo.

Punched Card Index

***QUESTION*: Some time ago one of the hospitals in London set up a punched card system for indexing neoplasms. I am now in a cancer clinic and would like to review this system. Do you know of any literature I can obtain?**

ANSWER: The Royal Cancer Hospital set up a mechanically sorted punched card index approximately 10 years ago. I believe the card carried about 60 factors. You might be able to get a copy of the system by writing to the printers in Great Britain; Benham and Company, Limited, Colchester.

If there has been a publication on the system since the second edition, I am not aware of or acquainted with the more recent one.

Correspondence Courses

***QUESTION*: Is there a correspondence course available in the United States for Medical Record Librarians?**

ANSWER: The American Association of Medical Record Librarians is now working on a correspondence course for Medical Record Librarians. For information relative to this course, I would suggest that you write directly to Miss Sara McKinney, 840 North Lake Shore Drive, Chicago, Illinois.

Electroshock Therapy

***QUESTION*: Recently during the hospital treatment of a patient, a local psychiatrist was consulted and electroshock therapy was given. These treatments were continued and the results were gratifying but no record of treatment was mentioned other than in the nurses notes. Can you advise me what type of record should be incorporated into the medical chart?**

ANSWER: By all means there should be a record of the electroshock therapy treatment on the medical record. If you do not have a specific form to accommodate such treatments, make sure there is an order for such treatment on the record and a progress note relative to the treatment. The fact that the treatment is mentioned on the nurses note sheet is not sufficient.

Signing Physician's Orders

***QUESTION*: We have three attending physicians working in our hospital and it is not at all unusual for a medical record to come to the department with all three of their signatures on physican's orders. Can there be more than one attending physician responsible?**

ANSWER: I think you will find the cardinal rule to be that only one physician at a time may be in charge of a patient. Of course the intern or resident may leave orders but in such instances they are under the direction of the attending physician. The attending physician who may not always be immediately available, may designate someone to assume responsibility. Another instance where more than one physician would leave orders would be where there is legal partnership. I believe you will find this matter discussed in the "Principles of Medical Ethics" published by the American Medical Association.

Group Supervisor

***QUESTION*: What does group supervision in medical records consist of?**

ANSWER: Group supervision in the practice of medical records means one registered record librarian carries the responsibility for the medical record departments in more than one hospital. Group supervision is carried out in one of two ways. A large hospital may share its medical record librarian with a small one or a medical record librarian may divide her time among several small hospitals. The number will depend upon the size of the hospital and the location of the hospitals. In any case the group superviser trains the non-professional personnel and works with the administrator and the medical staff.

Intake and Output Records

***QUESTION*: Who is responsible for completing intake and output records?**

ANSWER: The keeping of intake and output records is a function of the nursing service.

Excerpt Insurance Form

***QUESTION*: What is meant by an excerpt insurance form? I heard this term used at a recent local record librarians meeting.**

ANSWER: What the individual was referring to is the report form which comes to you from the Insurance Company, usually after the patient has been discharged and paid his own bill. ■

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Inter-Agency Institute for Federal Hospital Administrators

Left to right: Col. Malcolm H. Sawyer, director, Base Medical Services, Nellis Air Force Base, Nevada; Dr. Charles U. Letourneau, editorial director, Hospital Management; Miss Muriel McKenna, librarian, VA Central Office, Washington, D.C.; and Col. J. W. Barr, Commanding Officer, Canadian Forces Hospital, Kingston, Ontario.

Mississippi Hospital Association — Public Relations Conference

Helming the Conference were left to right: MHA President Reed B. Hogan; S. B. Wise, secretary-treasurer of the Mississippi Association of Hospital Governing Boards; C. J. Foley, public relations consultant, Wayne, Illinois; Richard C. Williams, executive director of the Mississippi Hospital and Medical Service; and Charles Flynn, executive director of MHA. The conference attracted 91 representatives of hospitals throughout the State of Mississippi.

Washington State Hospital Association

William E. Murray (right), president and Dr. Robert F. Brown (center), president-elect, presented a plaque to retiring president L. D. McIntyre at the conclusion of the two-day annual meeting of the Association held in Spokane.

The Academy of Hospital Counselors

■ THE FOLLOWING officers were elected: President Louis Block, Ph.D.; First Vice President Fred A. MacNamara; Second Vice President Alfred Maffly; Secretary Charles U. Letourneau, M.D.; and Treasurer Tracy Hare.

Chief items of consideration were the establishment of a code of ethics for hospital counselors and qualifications for membership.

The Academy of Hospital Counselors, has transferred its headquarters to Chicago. The address is:

Academy of Hospital Counselors
105 West Adams Street
Chicago 3, Illinois.

Hospital Association of Rhode Island

Right: Newly elected President J. Dewey Lutes, superintendent of Woonsocket Hospital and Left: Rev. Stephen K. Callahan, immediate past president, of Association and secretary to the Bishop for Hospitals, Diocese of Providence.

Indiana Hospital Association

■ OFFICERS ELECTED by the Indiana Hospital Association at their annual convention for the year 1960-1961 are as follows: President Wilbur C. McLin, administrator, Community Hospital, Indianapolis; President-Elect Richard W. Trenkner, administrator, Memorial Hospital of South Bend; Vice President Jack A. L. Hahn, director of Methodist Hospital, Indianapolis; and Treasurer Edmund J. Shea, administrator, Indiana University Medical Center.

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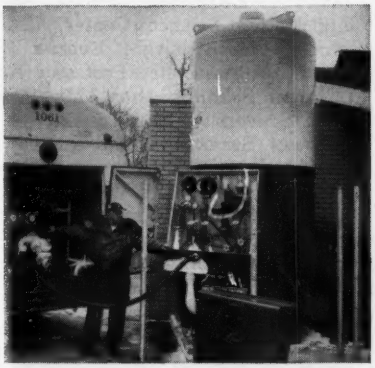
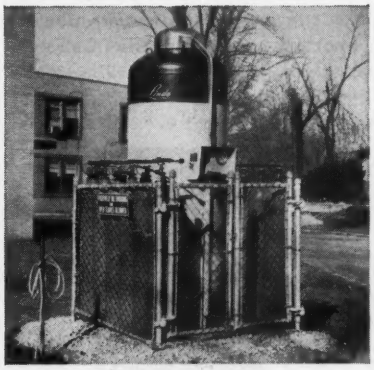


Surprisingly compact, this 90 VCC unit holds 90,000 cu. ft. of oxygen. It's a relatively small package because at atmospheric pressure liquid oxygen in its gaseous state would require 862 times more storage space.



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Both portable and compact, the LC-3 container can be moved about by one man—yet holds 3000 cu. ft. of oxygen, the same as 12 conventional cylinders. LC-3's can be used at the bedside or manifolded to provide a continuous supply to the piping system.

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a.c.h.a. activities

A new award, "Executive of the Year" was presented to CLARENCE B. RANDALL, retired Chairman of the Board of Inland Steel Company, by the American College of Hospital Administrators.

Mr. Randall was honored at a special Congress Awards Luncheon held in the Grand Ballroom of the Morrison Hotel on Friday, February 3, during the Fourth Annual Congress on Administration.

ACHA PRESIDENT MELVIN L. SUTLEY made the award—a special medallion—to Mr. Randall for his administrative achievements in the fields of commerce, education, philanthropy, government and community affairs.

In addition, President Sutley presented the James A. Hamilton Administrators' Award to PROFESSOR MELVILLE DALTON for his book, *Men Who Manage;* the Article Award to RAY E. BROWN for his article, "The Nature of Administration", published in *The Modern Hospital;* and the Edgar C. Hayhow Award to PROFESSOR WARREN G. BENNIS for his article, "Problem-Oriented Administration", published in the winter issue of *Hospital Administration,* the quarterly journal of the College.

C. B. Randall

Mr. Randall is among the most articulate of American spokesmen for enlightened free enterprize. He has contributed numerous articles to national magazines and is the author of four books: *Civil Liberties and Industrial Conflict* (co-authored with Roger N. Baldwin); *A Creed for Free Enterprise; Freedom's Faith;* and *A Foreign Economic Policy for the United States.*

For the first time at any of the College-sponsored Congresses on Administration, 20 authors of significant articles in the field of administration led off each Management Seminar with summaries of their research and findings.

Among the distinguished participants at the morning seminars were: PROFESSOR HENRY EILBURT, Bernard Baruch School of Business and Public Administration, City College, New York; DONALD E. BIRD, Associate Professor of Speech and Communication, Stephens College, Columbia, Mo.; FRANKLYN S. HAIMAN, Associate Professor of Group Communication, Department of Speech, Northwestern University, Evanston, Ill.; WARREN G. BENNIS, Associate Professor in the School of Industrial Management, Massachusetts Institute of Technology, Cambridge.

Other seminar guest speakers were: HAROLD F. ROTHE, Manager of Personnel, Fairbanks, Morse & Co., Inc., Beloit, Wis.; JOHN K. HEMPHILL, Director, Executive Study, Educational Testing Service, Princeton, N.J.; DONALD C. PELZ, Program Director, Survey Research Center, University of Michigan, Ann Arbor; JAMES D. THOMPSON, Director, Administrative Science Center, University of Pittsburgh; EUGENE E. JENNINGS, Associate Professor of Business Administration, Michigan State University, East Lansing.

PERRIN STRYKER, member, Board of Editors, *Fortune Magazine,* New York City and C. EDWARD WEBER, Associate Professor, Department of Industry, School of Business Administration, University of Pittsburgh.

A display of the top-flight books in the field of administration and management were a feature of the Book Mart of the Fourth Congress on Administration.

More than 20 leading publishers contributed books to the Mart, including John Wiley & Sons of New York, who published *Men Who Manage,* this year's prize-winning book. Author Melville Dalton, Professor of Sociology and Anthropology at the University of California in Los Angeles, autographed copies of his book at the Mart.

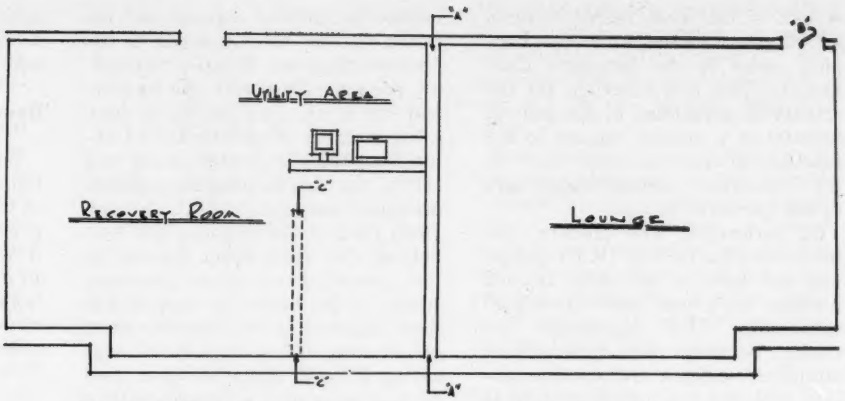

Figure 1. Floor plan of the recovery room and lounge, sixth floor, John Gaston Hospital. For explanation of letters, see text.

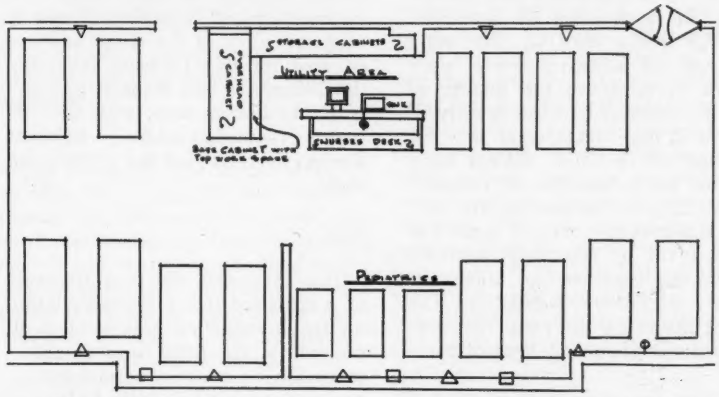

Figure 2. Plan of the finished structure, showing location of various items of installed equipment.

△ *—Two each vacuum inlets, vacuum bottles brackets, oxygen outlets and blood pressure manometers. One each double monitoring inlet box and 115 volt duplex electrical outlet.*

□ *—One each vacuum inlet and vacuum bottle bracket.*

ϕ *—One each vacuum inlet, vacuum bottle bracket, single monitoring inlet box and duplex electrical outlet.*

○ *—One double duplex electrical outlet.*

Design and Construction of an Intensive Care Facility

Maximum versatility at minimum cost

This hospital combines facilities for intensive care and for postoperative care

Part I (in this issue)—location, size, design, installed equipment, central monitoring system.

Part II (in March issue)—Noninstalled equipment, administrative policies, staffing, costs, income and table of costs of installed and noninstalled equipment.

by William H. L. Dornette, M.D.

and Richard L. Durbin, M.B.A.

Dr. Dornette is professor of anesthesiology and head of the department, University of Tennessee College of Medicine; anesthesiologist-in-chief, The John Gaston Hospital, Memphis, Tenn.

Mr. Durbin is now director of outpatient services, Presbyterian-St. Luke's Hospital, Chicago, but at the time the manuscript was prepared he was associate administrator, City of Memphis Hospitals, Memphis, Tenn.

■ ONE of the most recent features introduced into the American hospital scene is the Intensive Care Facility. This unit functions for the acutely ill population of the general hospital in a manner similar to the function of the recovery room in the immediate postanesthesia care of the operative patient.

In performing this function, the intensive care facility (ICF) groups into one location especially trained nursing personnel and specialized equipment. This equipment includes: recovery room type beds or stretchers; oxygen and suction outlets; hypothermia, monitoring, oxygen therapy equipment; airways, laryngoscopes, endotracheal tubes; and instrument sets such as those needed for tracheotomy and thoracotomy. In performing its functions, the ICF helps alleviate the acute shortage of skilled private duty nurses. It improves the quality of the care rendered to the acutely ill patient. It also furnishes an area for teaching of optimum patient care, and for the conduction of research in patient care techniques. The ICF also improves the care of those less seriously ill by removing from the care areas reserved for them the acutely ill patient population. The recent literature has contained several articles about this type of facility.[1-4]

During the early part of 1959, it became apparent that an intensive care facility was needed in our institution to supplement conventional nursing units for several types of patients. These types included postoperative cardiac patients; candidates for prolonged hypothermia, such as patients with neurological problems; candidates for prolonged cardiovascular and other types of monitoring; patients with other cardiovascular problems and severe respiratory disorders. A committee was formed to determine the best location for, design of, equipment to be installed in and administrative policies of the proposed facility.

Location

It is fairly obvious that in any new building program, space is allocated in optimum amount and location to best fill the needs of the finished structure. In most remodeling programs, however, the location and size of any new facility is often a compromise. When the John Gaston Hospital was erected in the mid 1930's, the house officer's quarters occupied the east half of the top (6th) floor of the building, the west half of this floor being devoted to the operating suite and recovery room. In the center portion of this floor, adjacent to the recovery room on the west, was a large room measuring 27 by 22 feet which was used as a lounge and equipped with a pool table, easy chairs and later a television set.

The subsequent availability of house officer's quarters elsewhere in the City of Memphis Hospitals released much of the space formerly used for this purpose, including the lounge. It was decided to combine the lounge area with the recovery room immediately adjacent thereto by removing the intervening wall.

Size

The projected size requirements of a proposed ICF are ideally based on the average ratio of acutely ill patients to the total hospital population. In an acute general hospital, one may expect this ratio to be 1 in 20 or 5 percent. Thus, a hospital of 200 beds should plan for an ICF of ten-bed capacity. Obviously, this ideal cannot always be met in a remodeling program.

The capacity of the recovery room of the John Gaston Hospital before the advent of the ICF was seven to eight patients. Preliminary studies of the blue prints and measurements of the affected areas suggested that a total of 17 bed positions might be accommodated in the expanded area. Because much of the equipment, both installed and noninstalled, that is used for post anesthesia recovery care is also used for intensive care, it was decided to combine the two facilities and admit both types of patient to the same room.

The senior author of this article approached the prospect of mixing recovery room patients and intensive care patients with some misgivings. Although similar equipment is employed for the care of both types of patients, nursing care differs rather markedly in some respects, and it did not seem practical nor safe to intermix the two groups of patients. This problem has apparently been solved satisfactorily in a manner described below under administrative policy.

Design

Since several members of the administrative and professional staff of the hospital had had previous experience with hospital remodeling, it was decided to allow these men to draw up the plans and specifications, and later supervise the construction of the ICF with the assistance of the general contractor. This approach proved highly satisfactory. The authors, acting as "architects in residence," were able to quickly meet and resolve the many small problems that inevitably arise in remodeling programs of this type.

As an initial step, prior to preparation of the specifications, a scale drawing (*figure 1*) of the two affected rooms was prepared. The capacities of the various areas for beds, desk, cabinets and the like was determined. Physical changes to the structure of the building, shown on this drawing, included the following: removal of the wall (A-A, *figure 1*) between the two rooms; enlargement of one doorway (B, *figure 1*) to accommodate beds and stretchers: and the erection of a ceiling to floor partition (C, *figure 1*) to separate adult male patients (to the west) from adult female and pediatric patients (to the east). The utility area (D, *figure 1*) was allowed to remain intact, since it would be centrally located within the new facility and of adequate size. Specifications conveying these aspects of the construction were prepared and transmitted to the general contractor, along with copies of this drawing.

Installed Equipment

A second scale drawing (*figure 2*) was also prepared. Various items of installed equipment were outlined on this drawing as explained in the caption of this figure. Specifications for this equipment and copies of the drawing were transmitted to the plumbing, electrical and woodworking contractors.

In any new construction, the use of flush mounted oxygen, vacuum and electrical outlets is highly desirable. When remodeling, however, it is often far more practical to employ surface mounted boxes. We have done so, but by extending all connecting tubing and conduit directly downward into the floor have

[1] Beardsley, J. M. et al: Centralized treatment for seriously ill surgical patients. J.A.M.A. 162: 544-547 (October 6) 1954.
[2] Cunningham, R. M. Jr.: Tomorrow's hospital must be different. Architect. Forum 92: 116-122 (February) 1959.
[3] Cadmus, R.: Special care for the critical case. Hospitals 28: 65-66 (September) 1954.
[4] Claussen, E.: Categorization of patients according to nursing care needs. Military Med. 116: 209-214 (March) 1955.

minimized the unsightly appearance of the exposed piping. These features are illustrated in *figure 3*, which shows a pair of typical bed positions.

Each bed position was equipped with one Puritan oxygen outlet, one Puritan vacuum outlet and vacuum bottle bracket, one W. A. Baum wall blood pressure manometer and one monitoring outlet described below. We selected Puritan outlets because they allowed interchangeability of ICF equipment with operating suite apparatus already so equipped. Male stems fitting the female wall outlets in the ICF also fit the valves on the ends of the ceiling drop hose fixtures in the operating rooms, and vice versa, without need for special adapters. One duplex electrical outlet was installed between each two beds. To afford sufficient vacuum outlets for patients requiring gastric and/or chest suction as well as oropharyngeal suction, four of the bed positions along the south wall of the ICF were equipped with a second vacuum outlet and vacuum bottle bracket.

Central Monitoring System

At the present time, little has appeared in the literature concerning this practice.[5,6] Central monitoring affords study at one centralized location of the physiologic processes of one or more patients located remotely from the monitoring equipment. Such practice saves space at the bedside, allows one individual to perform multi-patient monitoring and minimizes the cost of purchasing a monitoring unit for each patient. The installation in conduit of the connecting circuits avoids the hazard of draping the cables across the room.

The central monitoring system installed in our ICF was designed to afford maximum versatility at minimum cost; to allow for future expansion of both number of circuits and type of signal to be monitored; and to allow for the future possible use of other systems not now concurrently employed for remote physiologic monitoring. All installed components of this system are commercially available stock items. The system consists of bedside input terminals, interconnecting conductors, and a centrally located terminal box, bed selector switches and

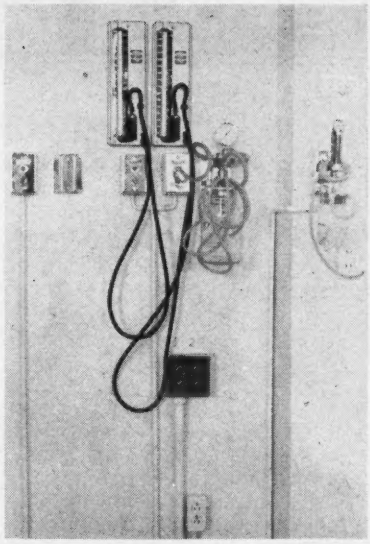

Figure 3. Wall-mounted equipment installed between each pair of bed positions.

output terminals. The input terminals were located in standard double duplex convenience boxes, one of which was mounted between each pair of bed positions. The bed side monitoring input stations were paired to minimize the cost of installation. The floor of the facility is of terrazzo. All pipes—oxygen, vacuum, electrical power and monitoring conduit—from each bed pair were conveyed through a hole of two and one-half inch diameter drilled through the terrazzo with a diamond studded masonery drill.

Each double duplex convenience box was equipped with a chrome plated cover drilled with two holes of ⅞-inch diameter and two of ⅜-inch diameter. Two five conductor female sockets (Amphenol number AN 3102A-14S-5S) were affixed to the ⅞-inch holes (*figure 4A*) and two (Switch Craft number 11) two conductor female phone jacks (*figure 4B*) to the ⅜-inch diameter holes.

Incidentally, how is the drive for the new recovery room coming?

Each double duplex convenience box was connected to the central terminal box by a one-inch conduit (*figure 4C*) that was extended through the crawl space beneath the floor. The central terminal box (*figure 5A*), measuring 30 inches wide by 20 inches high by 6 inches deep, was fabricated from galvanized sheet iron. The one-inch conduits from the bed positions were fed into the bottom of this box, in which was installed nine terminal strips of 30 terminals each. Each conductor from each of the bed positions was soldered to a terminaal on one of these strips. From the other end of each terminal other conductors convey the signal into the switchboxes.

Each of the monitoring inlet boxes was connected to the central terminal strip with Beldon number 8766 cable, which contains 15 shielded pairs of number 22-gauge solid copper wire. This wire possesses a capacitance of 40 micro farads per foot, which is far below the amount that may interfere with the transmission of an electrocardiographic or electroencephalographic signal, even along cable lengths of 100 feet.

The two conductors from the phone jacks of each of the 17 bed positions were conducted to the terminal strip and thence to a bed selector switch box (*figure 5B and figure 6*) containing a 20-position two-deck switch (JBT switch number MS-20-2S). Only 17 positions of this 20-position switch are utilized. The two conductors from the phone jack at each bed position were fed to each deck in sequence so that when the switch is turned to one of the bed positions, according to the switch card on the box (*figure 6*), the signal from that bed position will be conducted to the wiper terminals of the switch and thence to the output phone jack on the switchbox. A Yellow Springs Telethermometer (Model number 43-TA) was plugged into this output jack (*figures 5C and 6*). Yellow Springs Instrument Company number 401 rectal-esophageal temperature probes are inserted into the phone jacks at the respective bed positions and connected up to the patient. Because these probes are interchangeable, it is possible to monitor the temperature to any one of the 17 patients in the room merely by

[5] Dornette, W. H. L.: Hospital planning for the anesthesiologist. Springfield, Thomas, 1958. p 42.

[6] Dornette, W. H. L. and Brechner, V. L.: Instrumentation in anesthesiology. Philadelphia, Lea & Febiger, 1959, p 229.

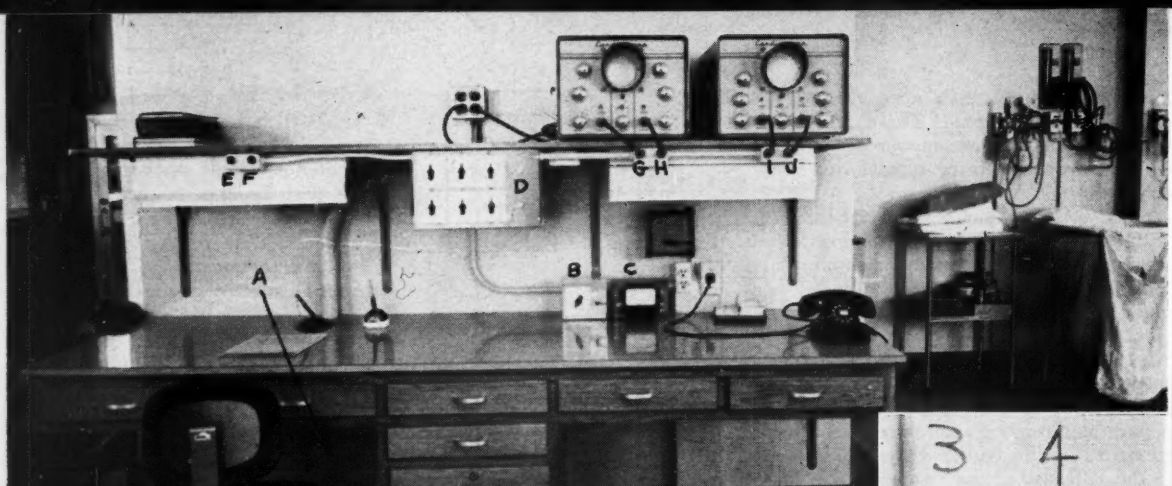

Figure 5. The nurse's desk showing switch boxes, outlets and equipment used for central monitoring. For explanation of letters, see text.

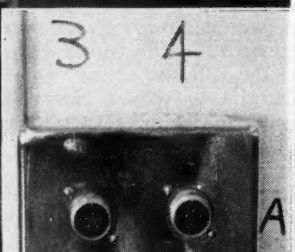

Figure 4. Close up view of a central monitoring bedside inlet box. For explanation of letters, see text.

proper adjustment of the switch, without the need for calibration of the individual probe. The Yellow Springs model number 43-TA telethermometer is a single channel stock instrument converted to multichannel application by the switching circuit and interchangable probes.

The larger (*figures 5D and 7*) of the two boxes containing bed selector switches was equipped with six 20-position switches, each of which has six decks. Seventeen of the positions were used, one for each bed position, and five of the decks, one for each of the five conductors from each five-conductor Amphenol socket at the bed side.

The wiper terminals of each of these six switches were fed into six Amphenol output sockets (*figure 5E, F, G, H, I, J*) similar to those employed at the bed sides. Thus any signal from any of the Amphenol plugs located at the bed side may be fed into any one of the six outlets. Currently, four of these outlets are connected to two dual trace Dallons Cardioscopes. This arrangement allows for study of the electrocardiograms of four patients continuously or any four of 17 patients intermittently. The patients whose electrocardiograms are to be studied are connected to the bed side Amphenol sockets by conventional Dallon's electrocardiographic lead cables.

There are two spare outlets. One of these is available for connection to a direct writing electrocardiograph. We employ the Burdick EK-III electrocardiograph because of its durability, simplicity of operation and high frequency response. The other spare outlet is currently being employed for the remote study of the patient's blood pressure with an Air Shields blood pressure manometer. Also under development are a cardiotachometer and a respiratory ventilation monitor. Details of the design and operation of these devices will be reported in a subsequent article.

The monitoring system was designed to allow for future expansion, to accommodate other methods of physiologic monitoring under development. Each of the bed side monitoring boxes contains 15 spare wires that are coiled up within the box. Centrally, these spare wires

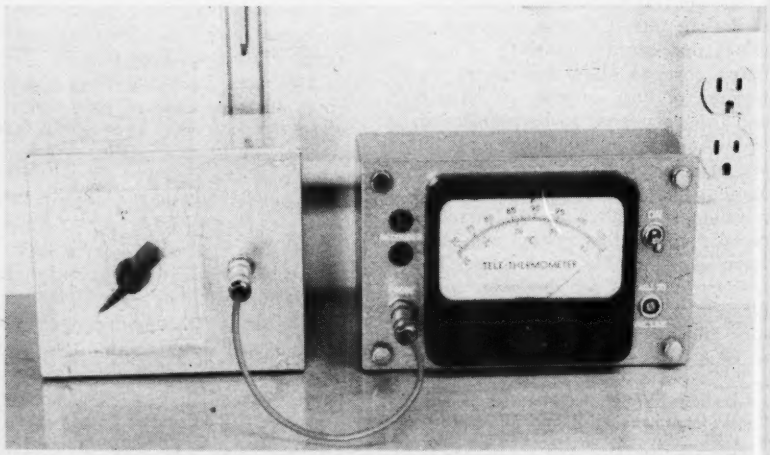

Figure 6. Close up view of Yellow Springs telethermometer and bed selector switch, used for monitoring the patients' body temperatures.

were connected to the terminal strip. Thus, any future expansion would be relatively simple. A second double duplex box would be fastened on top of the first one and the desired input sockets installed and connected to the spare conductors.

Versatility is one of the features of the central monitoring systems. It is possible, for example, to study the electroencephalogram of the patient remotely. Scalp electrodes are applied to the patient and these are connected to a Dallons electroencephalographic preamplifier. This preamplifier boosts the strength of the electroencephalographic signal about a thousand fold. The signal, so amplified, is fed into one of the Amphenol plugs and switched out into a cardioscope for continuous observation or into the Burdick EK III electrocardiograph for the preparation of a permanent record.

Other items of installed equipment included a nurse's desk and shelf above for the various items of monitoring equipment (*figure 5*); a base cabinet with a Formica top, shelves and sliding drawer; and a cabinet suspended over the base cabinet (*figure 8*). These cabinets allow for storage of many of the items of equipment used in the intensive care facility. *Figure 9* shows the completed facility.

The cost of remodeling this facility is shown in *table 1.*

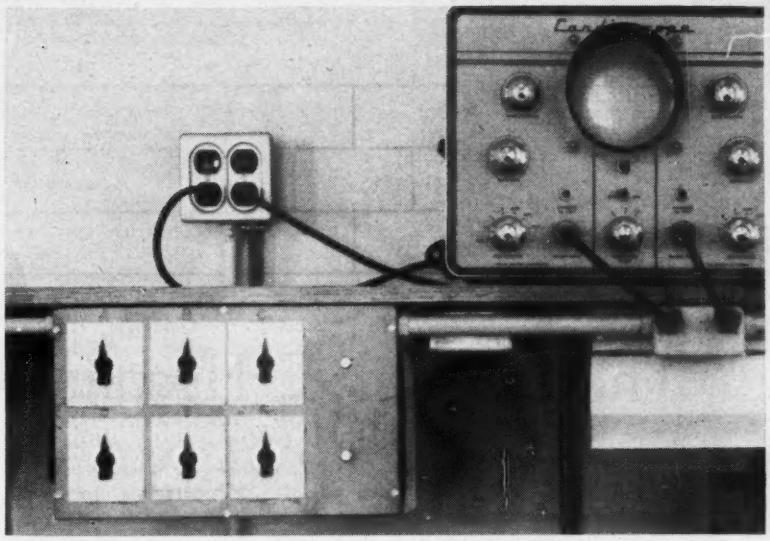

Figure 7. Close up view of bed selector switches used for switching the electrocardiographic signal from the bedside monitoring inlet boxes to the outlet boxes for study in the cardioscope of direct writing electrocardiograph.

Table 1. Cost of Physical Plant Renovation

Plumbing, electrical construction, cabinet construction and decorating	$6,540.00
Overbed curtains	1,870.00
Vacuum pump (Additional)	540.00
Total	$8,950.00

This feature will be concluded next month.

Figure 8. Cabinets installed adjacent to utility area for storage of equipment and supplies.

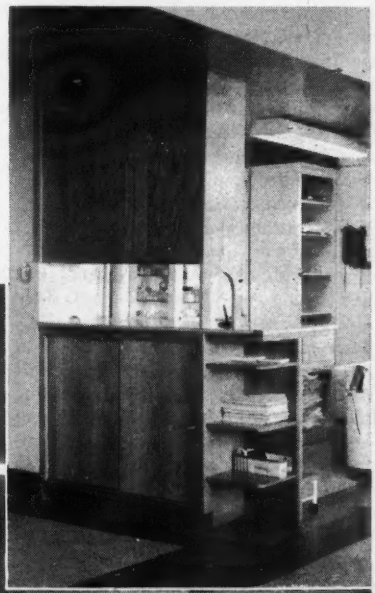

Figure 9. Completed ICF—Recovery Room combination. Nurse's desk is located in rear center of illustration with utility area just behind it.

by Charles U. Letourneau, M.D.

The Control of Hospital Costs Part II

Definitions of Cost

One of the greatest difficulties in attempting to control hospital costs is to obtain an adequate definition of *"costs."*

Hospitals are undertaking so many different kinds of enterprises which affect costs that it is important to know that reported costs mean the same thing to everyone concerned and that everyone agrees that the reported costs are uniform and include certain legitimate items. Up to now we have not been able to get this agreement.

It is mainly because we cannot get uniform agreement on the definitions of costs that many hospitals are being reimbursed upon their charges rather than their costs. There is a great need for a uniform cost-accounting system in hospitals to serve as a basis for a reimburseable cost formula to which all will agree. In years past, there were many attempts made to establish a workable reimburseable cost formula but few of them were ever adequate to our needs. Most of them were short-lived.

There is considerable difference between *apparent costs* and *real costs.*

Apparent costs are those which are shown on the financial report of a hospital. In the matter of depreciation alone, apparent costs may vary widely. Some hospitals may tend to take too much while others take none at all. In hospitals operated by religious orders, services given by religious nuns are almost always underpriced and so may tend to show a lower cost. The services of volunteer workers are almost never included in the financial report and certainly do not figure in cost accounting.

Real costs on the other hand represent the money that would have to be paid if all of the services of all of the people in the hospital had to be paid for at a decent living wage. In the study of hospitals over 500-beds,* the average salaries of government hospitals were away and beyond the averages reported by the nonprofit hospitals. Part of this discrepancy may be because government hospitals receive relatively little free service from volunteers.

There is also a considerable difference between *total costs* and *operating costs.*

Operating costs represent the cost of delivering service to the patient only. Most hospitals also undertake associated enterprises which are not properly included in operating costs but must be paid for in some way or other. These are included in the **total costs.** Some hospitals prefer to report total costs only or attempt to equivocate total costs with operating costs. Among the associated enterprises may be included teaching programs of various kinds, research projects and services which may be maintained for the community at large. Some hospitals have large outpatient clinics which are charged to inpatient services. Carrying charges for the financing of capital expenditures are sometimes quite high and are reflected in the total costs. Comparisons between hospitals with paid up capital structures and those with heavy mortgages reflect a cost discrepancy which is often quite considerable.

There is very often a failure to discriminate between *fixed costs* which some people call overhead and *flexible costs* which represent the costs that vary with each patient treated. In most hospitals, the fixed costs are considerably greater than the flexible costs. **Fixed costs** go on all the time. They should be divided by the number of bed days in the hospital rather than by the number of patient days. Fixed costs are not affected by occupancy if they are calculated on a bed-day basis; but few hospitals calculate them this way. Fixed costs are lumped with flexible costs in such a way that a bizzare picture may be painted from month to month or from day to day. Costs go up with decreased occupancy because fixed costs must be spread over a smaller number of patients in the hospital. Thus, cost per patient day may vary as much as 20 percent from one month to the other when they are reported in this way.

Examples of the fixed costs include the cost of the building maintenance and the utilities and depreciation. Included also is equip-

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Presented to the National Conference of Health, Welfare and Pension Plans, Miami Beach, Florida, October 10, 11, and 12, 1960.

Part I of the article "The Control of Hospital Costs" appeared in the January, 1961 issue of HOSPITAL MANAGEMENT.

*Letourneau, C. U. and M. Ulveling: Hospital costs — some influential factors, HOSPITAL MANAGEMENT, Nov., 1960 p 36; Dec., 1960 p 40

ment, whether it is used or not; because obsolescence takes as much toll as utilization.

In the fixed costs must be also included the stand-by personnel who must be on duty to deal with any emergencies that may arise. In this respect, the basic or fixed costs in the hospital are analogous to the fire department in a city or the defense department of our nation. They cost a lot of money but everyone would rather pay more money to maintain them in the hope that we may never have to use them rather than face the catastrophe that will happen sooner or later.

Flexible costs are those which increase with occupancy and use of the hospital. In addition to the stand-by nucleus of personnel, more people of all kinds are needed with the increase in number of patients. More food, drugs, bandages, needles, laundry and supplies will be needed as more patients are being treated. But these costs also increase with outpatient visits even though they are charged to inpatient days—which again gives a false picture.

Some of you have mentioned the matter of overcharging on some items and undercharging on others. This consideration cannot be brought into this discussion as it tends to confuse our picture. We should deal strictly with costs of services rendered, whatever our concept of that may be. Charges do not necessarily reflect costs and often times bear no relation at all.

At this time very few hospitals are using a standard method of cost accounting which would enable an outsider to make a valid comparison between one hospital and another. Our study of 500-bed hospitals showed such a vast descrepancy between hospitals that unless we know exactly what kind of patients are being treated, for what diseases, and under what circumstances and what services are included in the figures, we have no basis of comparison. We just have figures.

Reduce Expense

It must be admitted that some hospitals could be less expensive than they are but the main consideration of reducing expense is to do it *without reducing the quality of care.* Expense could be reduced by greater and more useful employment of hospital volunteers. There are many people available in the United States who have time to spare and who derive genuine satisfaction from working in a hospital. But not enough hospitals have discovered the way to employ them to maximum advantage. The experience of a Texas hospital shows what can be done. In this institution, volunteers gave 30,000 manhours of work in one year which would have had to be paid for otherwise.

Some hospitals are also making excellent use of the elderly and handicapped in jobs which are within their capacities. Hospitals are able to obtain this type of work force at considerably less cost than the able bodied. These suggestions can result in some savings but such savings are relatively insignificant in relation to the total cost picture.

What hospitals must do to present a substantially more efficient cost picture in the light of the inevitable rise in wages of hospital employees is to borrow a leaf from the book of industry and to make better use of the hospital work force. Primarily we can try to make hospital workers more productive and secondly we can try to use less people to produce the same quality and quantity of service that we are producing now.

It is impossible in this short space of time to go into detail on the methods that could be used and all the areas which should be explored but there are many avenues open to us.

Community Planning

We could use fewer people to produce the same quality and quantity of service by means of community planning whereby some hospital services could be centralized and duplication of some services could be eliminated. One example is the pooled laundry facility. In some centers, several hospitals are operating their own laundries wastefully when good services could be available either from a commercial laundry or by a joint venture in a centralized laundry.

Centralized purchasing and warehousing could undoubtedly save a great deal of money for hospitals in larger centers. Group purchasing is saving as much as 16 percent over individual hospital purchasing. Some hospitals have eliminated portions of their bookkeeping departments by getting the work done more accurately and more cheaply in centralized electronic data processing centers.

The day is also coming when centralized preparation, processing and cooking of food will be available thus eliminating tremendous areas of kitchen space now being utilized wastefully at this time, and large numbers of kitchen workers who boost personnel costs.

How could we make the personnel we now have produce more service. At this time, the bad design and construction of our hospitals forces personnel to spend as much as 50 percent of their working time in walking from place to place. Hospital walking is a high-priced, unproductive activity.

Better planning of hospitals is one answer to this problem of cost. Every architect or builder of a hospital should be forced to employ a qualified consultant who knows how a hospital ought to operate in the light of modern scientific developments. Perhaps an architect should not be called in until a consultant and a qualified engineer have determined the dynamics of the institution.

Existing hospitals could be made more efficient by regrouping services in such a way that the most service is given to those who need it most. The intensive care unit is an example of this principle.

The use of the television in hospitals is still in its infancy although it has proved its worth in reducing costs over and over again.

As a final example there are modern distribution systems available which can send things from place to place instead of having them carried, pulled or pushed by people going up and down elevators or travelling miles of corridors. To paraphrase the industrial philosophy, *"never use a man where a gimmick can do the job."*

The foregoing principles of reducing hospital costs are well known to physicians and to hospital people. We know what needs to be done but we are conservative. We move slowly in accepting innovations. This is characteristic of all established professional people. All that we can offer you is the assurance that we are trying in our slow conservative way to do the things that we know ought to be done.

We will try to reduce costs by better planning, better building, better administration and better evaluation of the services that we render. We hope that you and your side will help to reduce costs by controlling the consumer who might be tempted to use our services wastefully. We hope that you will be patient. Drastic changes in hospital services cannot be wrought overnight. ■

A Comprehensive Anesthesia and Surgical Record

by Stephen N. Steen, Sc.D., M.D.
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St. Barnabas Hospital for Chronic Diseases

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St. Barnabas Hospital for Chronic Diseases

■ IN AN EFFORT to augment the value of biometrics, a chart for anesthesia and surgery was designed for use at St. Barnabas Hospital. This chart* is a major improvement over the previous techniques employed in that it permits the anesthesiologist and medical records section to codify and accumlate data more efficiently. The method of sorting and the actual punching of this surgical and anesthesia record is no different from that employed for standard keysort cards.

Description

The chart is composed of two sheets; namely: the card that will eventually be placed in the anesthesiologist's file and the face sheet, of paper composition, which will become the permanent record of the patient's chart maintained in the medical records section.

The inner portion of the chart has spaces in the first two lines for the insertion of information with respect to room, date of surgery, hospital number, age, hemoglobin, blood pressure, blood group, weight and condition of teeth. Below this information the chart has space on the left for the inclusion of the operative intervention, the anesthesia administered, and the pre-operative medications given to the patient. On the right-hand side appears the name of the surgeon and his assistant, the anesthesiologist, suture nurse and circulating nurse. Additional boxes are left to indicate the sponge count, type of drains and the number and kind of x-rays.

Vital signs, depth of anesthesia, administration of anesthetic agents and fluids may readily be used on this chart. The "remarks" column is provided below to indicate any additional information that might be appropriate or desired in the record.

*Available from McBee Company, 309 W. Jackson Blvd., Chicago.

Along the periphery of the card are 28 numbered blocks for codification of data relative to the patient's condition pre-, para-, and post-operatively.

Advantages

In contrast to many coded charts used for anesthesia and medical records, no information is imprinted on the periphery for the following reasons.

1. The rapid advances in the fields of anesthesia and surgery do not permit a definitive listing of procedures since the coding must allow for the inclusion of new procedures as well as excluding the outmoded ones.
2. Changes in specialization may result in portions of a card being unused and therefore can be utilized for other purposes. One can even change the classifications of any and all block numbers at will, provided the date of such a change is known.
3. Imprinting of information may result in lack of written data, for the tendency would be to circle the information and have the code clerk punch at a later date. All this would increase the errors of coding.
4. The restrictions imposed by the size of the card are eliminated in that sequential blocks can be used for coding. For example, if two blocks are so used simultaneously, 100 combinations are available as in our blocks five and six.
5. The cost is decreased when data is not imprinted. Additional reasons for employing this record are:
6. The chart is a standard 8½ by 11 inches that is comparable in size with the other medical sheets in the patient's record.
7. The back of the chart is horizontally lined and can be used for recovery room, post-operative, intensive care or investigational data.
8. The punching of the card is rapidly accomplished without the need of complicated and costly processing equipment.

Example with Discussion

An example of the use of this card as punched for a patient undergoing surgery with general anesthesia is illustrated (*figure 1*). Inspection of the classification of the block numbers (*table 1*) will readily demonstrate the transference of the written data from the record to the punch code card.

The illustration shows a patient 56 years of age (*block 1*), with an O Neg. blood type (*block 2*) and a hemoglobin of 9.8 grams, with normal bleeding and coagulation times and normal prothrombin and fibrinogen levels in the blood (*block 3*). This patient is a female and an anesthetic risk of 6 (*block 4*). The operation consists of a left pneumonectomy (*blocks 5 and 6*) and the lower left hole in the left upper corner is punched to indicate that the left side of the body is involved. The upper righthand corner shows the initial C, indicating the first letter of the patient's surname.

During the left pneumonectomy this patient received local infiltration at the sight of incision (*block 7*), with procaine (*block 8*). Induction was with intravenous (*block 7*) thiopentone in small intermittent doses (*block 8*) and the anesthesia was maintained with continuous nitrous oxide + oxygen inhalation (*blocks 7 and 9*). For ease of surgical manipulation and to maintain a light plane of anesthesia as well as to allay post-operative pain, intermittent administration of a narcotic, (demerol) (*block 7 and 8*), and a continuous IV drip of a muscle relaxent (succinyl choline), which is not an anesthetic agent, was employed (*block 8*). This administration of the inhalation anesthesia was by means of a nonrebreathing system (*block 10*), em-

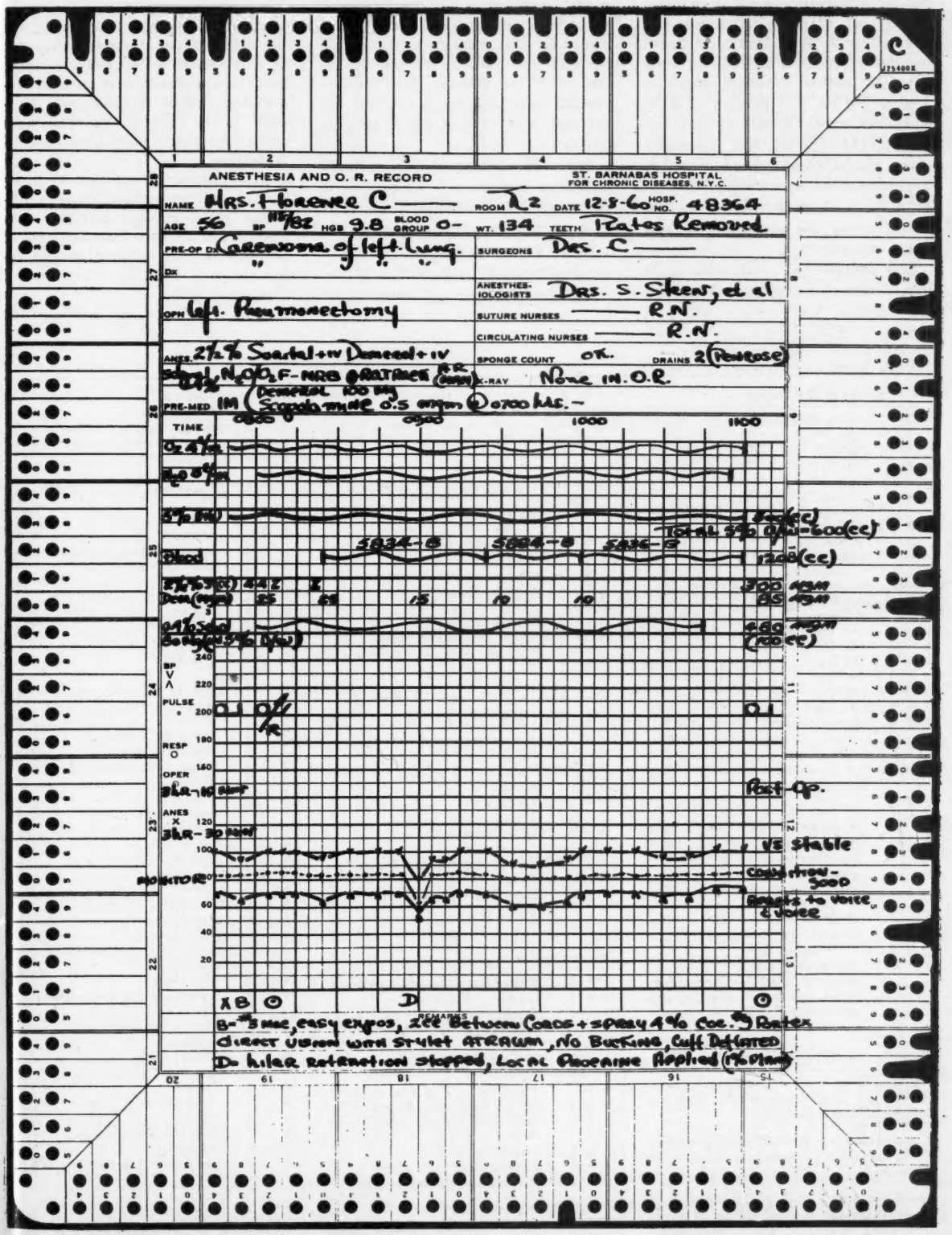


Figure 1. Punched card for patient undergoing surgery.

ploying a cuffed oro-endotracheal tube and an oral airway (*block 11*). Respirations were assisted by manually squeezing the breathing bag at a rate of 14 to the minute without the application of negative pressure (*block 12*). The patient was positioned with the right side down for ease of surgical exposure (*block 13*). The patient received approximately 500 cc of 5 percent D & W and 1200 cc of blood in the O.R. (*block 14*). During the procedure there was a short period of reflex hypotension easily corrected (*block 17*). Since hypothermia was not used during the operation, (*block 21*) is not punched.

The notation of vital signs is at five-minute intervals on the graph and the thicker vertical lines indicate time intervals of 15 minutes. No figures are imprinted for the time in hours and, thus, one may start at the extreme left of the chart to avoid wasting space. If desired, these time intervals could be of any duration; for example, each thick vertical line could correspond to one hour, the thinner lines for 20-minute intervals and thus allow for the collection of data for as long as 14 hours.

This chart can be punched-coded to indicate the time elapsed for surgery and anesthesia, the staff participating in the operation, the type of patient accommodation and its location, and for pertinent information that may be required by other departments, such as the intensive care unit, physical medicine and rehabilitation, accounting.

Conclusion

In reviewing the advantages and the descriptive example presented in this report it becomes apparent that the anesthesia and surgical record designed at St. Barnabas Hospital is a simple, comprehensive system for punch coding medical information.

This record, in addition to being a valuable instrument for accumulating and recording data for over 1,000 surgical cases, has also proved to be a worthy adjunct to the research and training programs of this institution. ■

Table I. Anesthesia and Surgical Classifications

Block 1—Age of the Patient

0	Birth—9 yr.
1	10—19 yr.
2	20—29 yr.
3	30—39 yr.
4	40—49 yr.
5	50—59 yr.
6	60—69 yr.
7	70—79 yr.
8	80—89 yr.
9	90—99 yr.

Block 2—Blood Group

0 — 3	Rh Positive
5 — 8	Rh Negative
0 + 5	O Type
1 + 6	A Type
2 + 7	B Type
3 + 8	AB Type
4 + 9	Other Types

Block 3—Blood Determination and Chemistries

0 — 4	Normal Range Value
5 — 9	Abnormal Range Value
0 + 5	Hemoglobin; abnormal values are considered to be below 10 grams. Thus where the patient has 9 grams of hemoglobin, 0 + 5 is punched.
1 + 6	Bleeding Time
2 + 7	Coagulation Time
3 + 8	Prothrombin Level
4 + 9	Fibrinogen Level
	Normal values for these chemistries can be decided in conjunction with the laboratory.

Block 4—Anesthesia Risk, et cetera

The anesthesia risks are numerically rated as per the classification of the American Society of Anesthesiologists.

If the patient is a female, hole 0 is punched. If the patient is a male, the card is left unpunched.

Anesthetic risks (which are classified 1 to 7) are punched, in combination, if necessary, using holes 1, 2 and 4 only. Thus a risk 7 would require punching all three holes. Hole 8 represents a cardiac arrest with death and hole 3 is a cardiac arrest during an operation with survival. Hole 5, 6, and 9 are available for other use.

Block 5—General Operative Classification**

0	Neck
1	Thorax
2	Upper Abdomen
3	Lower Abdomen
4	Abdominal Wall
5	Perineal Region
6	Vertebral Column
7	Extremities
8	Great Vessels and Heart
9	Eye, Ear, Nose, Dental Oral

Block 6—Subclassification of Block 5

0	HEAD, (not face) punched only, is a general classification.
0 — 1	PEG
0 — 2	Ventricles ('graphy, drainage, lavage)
0 — 3	Pallidectomy
0 — 4	Thalamectomy
0 — 5	Craniotomy
0 — 6	Trephination(s)
0 — 7	Frontal Lobotomy (Bimedial)
0 — 8	Deep
0 — 9	Superficial (biopsy, plastic of scalp)

Blocks 5 and 6

0 + 0	Angiogram (carotid, vertebra)
0 + 1	Larynx (incl'g-scopy)
0 + 2	Tonsils
0 + 3	Trachea (incl'g tracheostomy)
0 + 4	Thyroid
0 + 5	Carotid ligation
0 + 6	Tongue
0 + 7	Mandible
0 + 8	Deep (deep node dissection)
0 + 9	Superficial (biopsy, plastic)
1 + 0	Not to be used†
1 + 1	Bronchoscopy
1 + 2	Thoracic cage (rib resection)
1 + 3	Thoractomy
1 + 4	Esophagus
1 + 5	Breast (simple, radical)
1 + 6	Lung (partial, complete)
1 + 7	Extrapleural
1 + 8	Thoracentesis
1 + 9	Superficial (biopsy, plastic)
2 + 0	Not to be used†
2 + 1	Stomach
2 + 2	Small Intestine (duodenum, etc.)
2 + 3	Gall Bladder
2 + 4	Pancreas
2 + 5	Colon (cf: 3+5)
2 + 6	Spleen
2 + 7	Liver
2 + 8	Diaphragm
2 + 9	Not Used
3 + 0	Not to be used†
3 + 1	Appendix
3 + 2	Ovary
3 + 3	Fallopian Tube
3 + 4	Uterus
3 + 5	Large Bowel (cf: 2+5)
3 + 6	D & C
3 + 7	Cervix
3 + 8	Paracentesis
3 + 9	Bladder
4 + 0	Not to be used†
4 + 1	Inquinal
4 + 2	Ventral
4 + 3	Ureteral
4 + 4	Renal
4 + 5	Adrenal
4 + 6	Extra- and retro-peritoneal
4 + 7	Lumbar
4 + 8	Not Used
4 + 9	Superficial (biopsy, plastic)
5 + 0	Not to be used†
5 + 1	Prostate
5 + 2	Uretha
5 + 3	Scrotum (labia)
5 + 4	Testicle
5 + 5	Penis (clitoris)
5 + 6	Vagina
5 + 7	Sigmoid (incl'g scopy)
5 + 8	Anorectal
5 + 9	Superficial (plastic, biopsy)

**Block 5 should always be punched except for operations of the head.

†Not used in that punching here would confuse code classification.

6 + 0	Not to be used†
6 + 1	Cervical
6 + 2	Thoracic (for ribs, v. 1+8 in BLOCKS 5+6)
6 + 3	Lumbar
6 + 4	Sacral
6 + 5	Laminectomy
6 + 6	Coccyx
6 + 7	Not Used
6 + 8	Not Used
6 + 9	Not Used
7 + 0	Not to be used†
7 + 1	Humeral; radial, ulnar; femoral, tibial, fibular)
7 + 2	Metacarpal, carpal
7 + 3	Upper
7 + 4	Lower
7 + 5	Deep (incl'g osseous if no punch, superficial)
7 + 6	Not Used
7 + 7	Not Used
7 + 8	Not Used
7 + 9	Not Used
8 + 0	Cerebral Blood Vessels e.g. aneurysm
8 + 1	For Cardiac Surgery
8 + 2	
8 + 3	
8 + 4	
8 + 5	
8 + 6	
8 + 7	
8 + 8	
8 + 9	
9 + 0	Face, deep
9 + 1	Eye
9 + 2	Eye
9 + 3	Eye
9 + 4	Dental Oral
9 + 5	Ear
9 + 6	Ear
9 + 7	Nose
9 + 8	Nose
9 + 9	Superficial (biopsy, plastic of FACE)

Block 7—Route of Administration of the Anesthetic Agents

0	Local Infiltration of Tissue
5	Rectal Administration
1 + 6	Intravenous; the former referring to intermittent, the latter to continuous administration thereof.
2 + 7	Inhalation Agents
3 + 8	Spinal; the former referring to the one shot technique, the latter referring to a continuous technique with catheter or malleable needle.
4 + 9	Epidural; the former referring to the one shot technique, the latter referring to a continuous technique or malleable needle.

Block 8—Noninhalation Agents Administered

0 — 3	Intermittent Administration
5 — 8	Continuous Administration
0 + 5	Barbiturates
1 + 6	Narcotics
2 + 7	Ataractics
4	Procaine
9	Other agents

Block 9—Inhalation Agents Administered

0	Oxygen
1 — 4	Intermittent Administration
6 — 9	Continuous
1 + 6	Nitrous Oxide with Oxygen
2 + 7	Ether with Oxygen
3 + 8	Cyclopropane with Oxygen
4 + 9	Other agents
5	Air

Block 10—Technique of Administration

1	Open Drop
2	Insufflation
3	Semi-closed
4	Closed
5	Circle
6	To and Fro
7	Not in Use
8	Not in Use
9	Non-rebreathing

Block 11—Airway Classification

0	Mask
1	Oral Airway
2	Oro-tracheal
3	Placement of the tracheal tube under direct vision
4	Inflation of cuff on tracheal tube
5	Catheter, nasal
6	Nasal
7	Naso-tracheal
8	Tracheal tube positioned blind
9	Packing employed

Block 12—Respiration

0	Assisted, manual squeezing of anesthesia breathing bag
1	Controlled manual squeezing of anesthesia bag
2	Respiratory rate greater than 10 per minute
3	IPP—Application of intermittent positive pressure
7	Respiratory rate less than 10 per minute
8	IPNP—Application of intermittent positive-negative pressure
5 + 6	Machine squeezing of anesthesia breathing bag (5-assisted, 6-controlled)
4 + 9	Other techniques

Block 13—Surgical Position of Patient

	If patient is in the supine position, no hole is punched
0	Prone
1	Lateral position with right side down
2	Trendelenburg
3	Fowler
4	Kidney bridge, elevated
5	Sitting
6	Lateral position with left side down
7	Lithotomy
8	Buie
9	Other

Reprints Available

For reprints currently available, please see order form on pages 75 and 76.

The article by Dornette and Durbin beginning on page 35 will be available in reprint form in March following the publication of Part II.

The "contest rules" beginning on page 48 will be available soon in reprint form.

Block 14—Intravenous Administration of Fluids

0 — 4	Less than 1000 cc
5 — 9	Greater than 1000 cc
0 + 5	5% dextrose and water
1 + 6	Blood
2 + 7	Blood substitute expander
3 + 8	Plasma
4 + 9	Other

Blocks 15 & 16—Nerve Blocks

If Block 16 is punched at 0 then a nerve was involved during the operation. Otherwise Blocks 15 and 16 are used by the anesthesiologist to indicate the performance of a nerve block analgesia.

Block 17—Anesthetic Complications

0 — 3	Minor complications
5 — 8	Major complications
0 + 5	Gastrointestinal tract
1 + 6	Cardio-vascular system
2 + 7	Respiratory system
3 + 8	Technical problems
4	Post-operative tracheostomy
9	Tracheostomy during operation

Blocks 18, 19 & 20—Gas Sampling

These blocks represent sampling values for oxygen, carbon dioxide, nitrous oxide and other agents.

Block 21—Hypotherma Technique

Since body temperature on a centigrade scale is 37°, each numbered hole refers to the temperature in degrees of centigrade from 27° to 36°. For example, hole 1 would be punched for 31° centigrade.

The Upper Left Corner

This corner box has two holes; the punching of the left lower hole indicates an operation on the left side of the body. If the hole on the right is punched, then the operation was performed on the right.

The Lower Left Corner

This corner has two holes; an upper left and lower right hole. The latter is punched to indicate Parkinsonism and the other is punched for neuromuscular diseases other than Parkinsonism.

Upper Right Corner

The blank space may be used for filing purposes. In our institution, the first letter of the patient's last name is placed there.

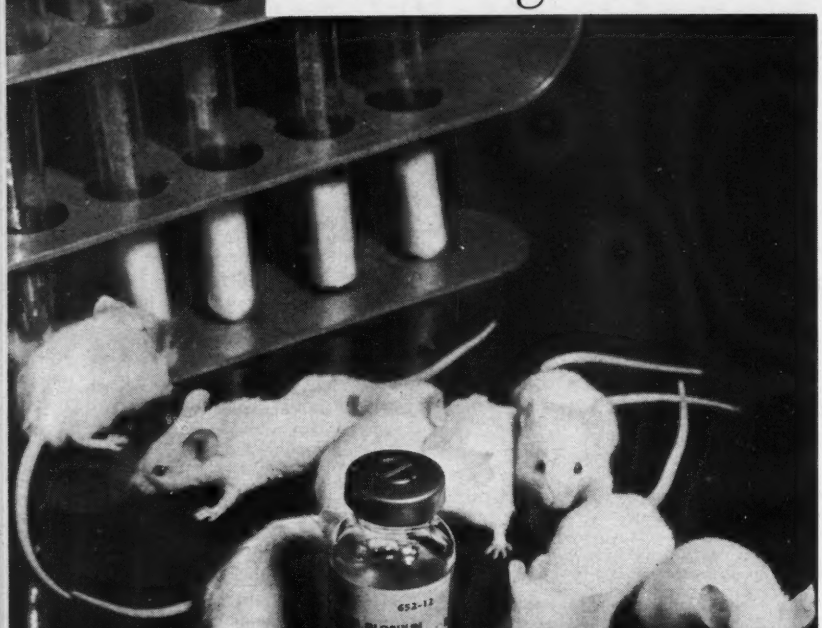
Lower Right Hand Corner

This corner has two holes. The upper right is punched if the patient has received anesthesia. The lower left is used when the patient was in a state of analgesia, whether the technique be local or otherwise.

Blocks 22 to 28

Have been preserved for investigational studies now being employed in our new operating room suite.

The Drug Manufacturers' Dilemma



by Robert K. Cutter, M.D.

President
Cutter Laboratories
Berkeley 10, California

■ IT HAS BECOME a rather common occurrence to read in the news about how a new wonder drug has been rushed to a hospital bedside in the nick of time to save a life from some heretofore fatal condition. When I see this, I can't help but recall the dilemma that we and other drug manufacturers face occasionally when deciding whether or not to market a new product.

The dilemma is basically this: Every reputable drug manufacturer has a feeling of moral responsibility to make available products which have life-saving potential. Should this moral responsibility be influenced in any way by principles of sound business economics?

This becomes a dilemma because the drug manufacturer, as a businessman, must accept the trust of his employees and investors to produce a profit. If he does not, he goes out of business and the employees, the investors and the public all lose. Unfortunately, many of the dramatic life-saving drugs that make the headlines are not always too compatible with this aim. Also, there is no "safe" gamble. Even the most promising product may boomerang, fail to "take," or be quickly displaced by a newer and more effective product. Moreover, there is a sizeable group of prospective products which, while they lack dramatic life-saving properties, are still important medically.

There are many reasons why these products present problems. Foremost is the fact that when subjected to a slide rule appraisal of their potential contribution to net profits, many are exposed as poor marketing risks. Very often the market for them is small and the cost of development, production and distribution is large. Also, sales volume, at least initially, isn't likely to be enough to permit fitting them into the total manufacturing job in an efficient manner. And it very often becomes necessary to hire specially trained technicians whose talents cannot be efficiently utilized. Even when there appears to be a nice spread between obvious production costs and the selling price of these products, there can be enough pitfalls buried in their production and marketing to make them poor investments.

This entire situation has never been a slide rule decision because there are generally too many values to be weighed: too much necessity to think with the heart; necessity to think with a deep conscience.

We of Cutter Laboratories have faced up to this situation quite a few times during the 61 years we've spent in the production of biologicals and pharmaceuticals, as the following examples will show.

Toward the end of World War II, after several years of pioneering in the production of human blood fractions, it became apparent that we would soon be facing a dwindling market for the military.

This raised the question of whether it would be more practical to get out of blood fractions or pursue the alternative of pioneering their preparation for the civilian market.

Certainly there were legitimate arguments to be voiced both pro and con. On the doubtful side of the ledger was the gamble which had to be taken on the civilian market itself. There were no precedents on which to lean, no assurance that the financial end result might not be a loss.

In the first place, we had an investment to consider in trained manpower and equipment—and excellent production facilities. Secondly, we felt certain that the promise of as yet undiscovered blood fractions would offer still more important weapons against unconquered disease conditions.

On the other hand, our experience had shown blood fractionation to be a costly process. We were dealing with human venous blood rather than placental material. This demanded unfailing attention to the whole-blood supply problem on a continuing basis. Further, the fractionation process was lengthy and critical and exacting standards had to be followed.

It appeared to be strictly a gamble from an economic point of view —a gamble on products which had long since been proved successful from a medical point of view. To say the least, it was a temptation to wait and let the other fellow play pioneer, then move in and pick up our chips after a market was assured.

We chose to establish centers for collecting the essential raw material, blood, from paid professional donors. The five other firms which had produced blood fractions for the military chose not to produce them for the civilian market.

There are many different sides to this dilemma. The case above was mainly a concern centering around the risk that commercial marketing of blood fractions would be a low volume, low profit venture which would tie up capital that could be put to other, more rewarding uses. We have had other experiences in which the gamble was something entirely different.

A very good example also falls into the blood fractions field. When our research efforts succeeded in purifying fibrinogen, the clotting factor in human blood, from plasma, we were face to face with a price situation which made the product a very questionable risk. No one's slide rule could comfortably predict that its medical importance would prevail over the resistance of the prescriber and the ultimate purchaser.

Yet, from a medical point of view, this was the very first practical means of presenting fibrinogen to the bleeding victim of afibrinogenemia (lack of fibrinogen in the blood) or hypoafibrinogenemia (low fibrinogen blood level). Its importance in saving lives during the complications of pregnancy, and following surgical procedures, and in various other situations where the patient is in danger of bleeding to death, was unquestionable.

Still, there was no escaping the fact that the cost to the patient for a single dose would be in the neighborhood of $50.00. Again, there was the temptation to let the other fellow take the chance. And, while we were deliberating this problem, some even suggested abandonment of the project.

In the final analysis, we reached the only possible conclusion, deciding that because it was truly a life-saving product we could not in good conscience withhold it from those who needed it. In other words, we felt that it was not up to us to decide that $50.00, $100.00, $200.00, or even more is too high a price for a man to pay to save his life or that of his wife or child.

To say the least, there have been enough flying trips through snow storms, police-escorted trips to hospitals, and even jet plane flights to rush this product to the bedsides of patients who would have died without it, to assure all of us that the right decision was made.

On the other hand, Cutter Laboratories is the living example of the fact that a biological and pharmaceutical manufacturer, in attempting to produce a product of tremendous potential benefit to humanity, can end up with a terrible calamity behind which the great financial loss dwindles to obscurity.

Prior to the polio vaccine incident, we were the only company to have produced a tissue culture vaccine. This was Viracine, a virus vaccine for prevention of cholera in swine. So it was only natural that when we were invited to take part in the polio vaccine program we accepted.

Through an unbelievable set of circumstances, only too late was it found that the testing procedure set up by the United States Government which we and other manufacturers relied on was not adequate under certain circumstances to detect infective quantities of virus in the vaccine. This has all been changed —tests were found which are much more sensitive—but it will be many years, if ever, before this horrible experience will be forgotten.

Government scientists who made a most thorough investigation of our plant, equipment, and personnel immediately following the incident, found no carelessness nor negligence nor incompetence: in fact, quite the opposite of this.

The medical profession, pharmacists, and hospital people were not misled by the castigation we received in the lay press and have continued to support us loyally. Nevertheless, we shall always look back with regret upon the day we decided to produce poliomyelitis vaccine.

Another example of slide rule indecision came in 1949 when we found that we could produce a skin test diagnostic agent for coccidioidomycosis. On the one hand, we knew that the product, Coccidiodin, would serve to meet a long felt need for a testing agent that was both efficient and safe. Further, because the disease was endemic in our area only, we felt that the responsibility was ours and not that of Eastern or Mid-Western firms. We felt that sales would be little more than piddling and, in addition, because of a short-dating situation, there was the danger that what chance there was for even a small profit would go "down the drain" with outdated material.

Here again, in the final analysis, our slide rule went back into its scabbard and a decision was made on the basis of the moral issue involved.

But here's the joker. This product was expected to be a pain in the neck has turned out to be a small but steady profit maker!

There are many other cases, but I'll cite just one more in which marketing of a product required a willingness to pioneer—a desire to gamble.

In the early forties when our researchers came up with a practical triple antigen combination (diphtheria-pertussis-tetanus) it seemed certain that it would be welcomed medically if for no other reason than that it reduced the infant's encounter with the immunizing needle from nine to only three injections.

There was no doubting that extreme change on the part of physician attitudes was necessary, and that this change had to occur within our ability to invest in its occurrence.

We went ahead, knowing that we would meet many Doubting Thomases along the way who would prefer to let someone else verify its immunizing ability and the safety of simultaneous immunization.

The chance taken here has proved to be a sound one. It not only established our product, Dip-Pert-Tet, as a bellwether in the field of combined vaccines—it also led to the earlier acceptance and broad use of this new immunizing concept.

I don't mean to infer that we as a manufacturer expect to market our products without risk of financial loss. On the contrary, we're aware of the pitfalls that threaten every product and are willing to take our chances along with everyone else.

What I hope is apparent, however, is the fact that our dilemma centers around the products which our industry "owes" to society, but which we as businessmen cannot get very excited about. I think that this entire situation touches on the Esprit de Corps of our industry which, amid demands that dividends be paid, gives consideration to the fact that there are richer dividends to be achieved in the form of abated human suffering when Mother Nature is kept from going into the red. ■

MacEachern Contest Time Again!

Annual Reports, Hospital Bulletins,

Public Relations Program and

Special Public Relations Projects

■ DO YOU publish an Annual Report? Do you have a Hospital Bulletin? Do you keep a record of all of your Public Relations Activities for the year? Have you had a special problem and found a solution? Are you interested in achieving national recognition for your hospital? If the answer to any of the foregoing questions is YES, then this contest is for you.

The MacEachern Public Relations Contests are held each year by HOSPITAL MANAGEMENT to promote better understanding between hospitals and the communities they serve.

The rules governing the contests are simple to follow. There are no forms to send for. The deadline is June 6, 1961, so you have plenty of time to prepare your entries. The material must be received at HOSPITAL MANAGEMENT by closing time on that date. **No extensions are allowed.**

All of the Public Relations Programs and Projects will be returned. The Annual Reports and Hospital Bulletins will not be returned, unless you specifically ask that they be returned.

The awards are presented during the American Hospital Association convention at HOSPITAL MANAGEMENT's *Breakfast of Awards.*

Over-All Public Relations Contest

One winner—Malcolm T. MacEachern Citation.

Honorable Mention Certificates—as determined by judges.

Entries in this contest are usually presented in scrapbook form and contain a running, illustrated account of the hospital's year-long public relations activities and programs.

General Information and Instructions: All hospitals are invited to submit entries in each contest provided such entries meet the requirements established for the particular contest. The *contest period* for all competitions is from June 1, 1960 through May 31, 1961. The *deadline* for all entries is midnight, June 6, 1961. Entries received after this date are ineligible to participate and will be returned.

Each entry must have an identification sheet or a label, glued or permanently affixed, containing the following information: (this applies also to the extra copies of annual reports and bulletins required in these respective contests):

Name of hospital
Address
City, zone, state
Type of hospital and bed complement
Name of administrator
Name and title of individual submitting entry

Special Instructions:

1. Each entry must be accompanied, in addition to identification sheet, by a letter summarizing briefly the hospital's public relations goals or objectives for the period covered and an evaluation or opinion of results achieved. It is very desirable to point out any reasons or circumstances which may have prevented complete attainment of the goals established.

2. The presentation should be arranged to indicate the hospital's public relations activities conducted *within* the hospital (among personnel, patients, visitors, auxilians, etc.) and then *outwardly* to the community (among special groups and organizations, schools, industry, press, radio, etc.). Short commentaries or summaries of public relations activities or techniques used in each area will enhance the presentation.

3. Pages of the scrapbook should be numbered. When possible, it should also be indexed according to the various categories or activities.

4. Special materials (clippings, folders, photographs, etc.) included

with the scrapbook should be fastened in securely.

5. Elaborateness, size or bulk are not key factors. The scrapbook should, however, be sufficiently durable to stand considerable handling. Because of the volume of material received in this division we must insist that you limit your presentation to ONE scrapbook.

6. Explanations of pictures, clippings and brochures should be included with each activity.

Public Relations Project Contest

One winner—Malcolm T. MacEachern Citation.

Honorable Mention Certificates—as determined by judges.

Entries in this contest are to present a documented account of how the hospital handled a specific public relations project or problem. For example, this might be concerned with such projects or problems as the following: interpretation of hospital costs; personnel recruitment; National Hospital Week observance; participation in Business-Education Day; a special anniversary program; a baby mix-up; a disaster in the area; a program designed to help personnel (or doctors, or auxilians) become better public relations representatives of the hospital.

General Information and Instructions: All hospitals are invited to submit entries in each contest provided such entries meet the requirements established for the particular contest. The *contest period* for all competitions is from June 1, 1960 through May 31, 1961. The *deadline* for all entries is midnight, June 6, 1961. Entries received after this date are ineligible to participate and will be returned.

Each entry must have an identification sheet or a label, glued or permanently affixed, containing the following information: (this applies also to the extra copies of annual reports and bulletins required in these respective contests):

Name of hospital
Address
City, zone, state
Type of hospital and bed complement
Name of administrator
Name and title of individual submitting entry

Special Instructions:

1. This entry must be accompanied by a letter summarizing the particular project or problems and describing briefly what was done, public relations-wise, to accomplish the desired results. Reasons or circumstances affecting the achievement of the objectives should be cited. (Hospitals so desiring may submit more than one entry in this contest.)

2. The presentation should elaborate on the information contained in the accompanying letter (Item No. 1 above) and include pertinent details and illustrative materials. A running commentary outlining or highlighting special aspects of the project or problem, as well as techniques or strategy used, will add value to the presentation.

3. Suggestions and recommendations contained under Items 3, 4, 5 and 6 of Special Instructions for the Over-All Public Relations Contest apply generally to the Special Public Relations Project Contest also.

Annual Reports Contest

Two winners—Malcolm T. MacEachern Citations.

One Citation for an abbreviated or summarized annual report which is distributed widely in the community.

One Citation for the traditional type annual report which is distributed on a limited basis (to donors, friends of the hospital, key individuals in the community, etc.)

(Note: Hospitals publishing both types of report may enter either or both reports in this contest.)

General Information and Instructions: All hospitals are invited to submit entries in each contest provided such entries meet the requirements established for the particular contest. The *contest period* for all competitions is from June 1, 1960 through May 31, 1961. The *deadline* for all entries is midnight, June 6, 1961. Entries received after this date are ineligible to participate and will be returned.

Each entry must have an identification sheet or a label, glued or permanently affixed, containing the following information: (this applies also to the extra copies of annual reports and bulletins required in these respective contests):

Name of hospital
Address
City, zone, state
Type of hospital and bed complement
Name of administrator
Name and title of individual submitting entry

Special Instructions:

1. *Three copies* of the annual report published during the contest period must be entered.

2. The three copies of the annual report must be accompanied (in addition to the identification sheet or label as per General Instructions) by the following information:

a) Entered for judging in the Annual Reports Contest for:

1. ———Abbreviated reports.
2. ———Traditional type reports.

b) Approximate number of copies published———.

c) Approximate number distributed ———.

d) List *types* — not names — of individuals (medical staff members,

With the three copies of your Annual Report entry be sure to include an identification label, as well as, other information asked for under General and Special Instructions.

clergymen, state legislators, etc.) or organizations (libraries, newspapers, schools, local agencies, etc.) to whom report was distributed:

e) Describe briefly the guiding theme, special purpose, or other pertinent information about this report which should be of interest to the judges:

f) If a letter or memo accompanied report, include sample copy with each report.

g) Was this report prepared and edited entirely by hospital personnel? ——. If "no," describe briefly *type* of outside assistance received (consultant, advertising agency, etc.):

h) Estimate approximately how much report cost *per copy* exclusive of distribution (postage or other) cost: ———.

i) Evaluate briefly the report's reception and value to the hospital's over-all public relations program:

Hospital Bulletins Contest

Three winners — Malcolm T. MacEachern Citations.

One Citation for best "internal" bulletin.

One Citation for best "external" bulletin.

One Citation for best combination-type bulletin.

Honorable Mention Certificates — as determined by judges.

(Note: Hospitals publishing both "internal" and "external" type bulletins may enter either or both in contest.)

General Information and Instructions: All hospitals are invited to submit entries in each contest provided such entries meet the requirements established for the particular contest. The *contest period* for all competitions is from June 1, 1960 through May 31, 1961. The *deadline* for all entries is midnight, June 6, 1961. Entries received after this date are ineligible to participate and will be returned.

Each entry must have an identification sheet or a label, glued or permanently affixed, containing the following information: (this applies also to the extra copies of annual reports and bulletins required in these respective contests):

Name of hospital
Address
City, zone, state
Type of hospital and bed complement

Name of administrator
Name and title of individual submitting entry

An identification label is needed on the nine (9) copies of your entry in the Hospital Bulletins Contest, in addition to the other material requested in the General Instructions and Special Instructions.

Special Instructions:

1. *Three copies each of three consecutive* bulletins published during the contest period must be entered.

2. The three sets of bulletins must be accompanied (in addition to the identification sheet or label as per General Instructions) by the following information:

a) Entered for judging in Hospital Bulletins Contest for:

1. —— "Internal" bulletin category.

2. —— "External" bulletin category.

3. —— Combination-type category.

b) Average number of copies published per issue ——.

c) Approximate number of copies distributed per issue. ——.

d) Are mail copies sent as: —— self-mailer; —— in envelope.

e) List *types* — not names — of individuals (medical staff members, employees, local health and welfare officials, etc.) organizations (service clubs, industries, newspapers, etc.) to whom bulletin is distributed:

f) Describe briefly purpose or objective of bulletin:

g) Are bulletins prepared and edited entirely by hospital personnel? ——. If "no," describe briefly *type* of outside assistance received (consultant, advertising agency, etc.):

h) Estimate approximately how much bulletin costs *per copy* exclusive of distribution (postage or other) cost: ——.

i) Evaluate briefly the bulletin's reception and value to the hospital's over-all public relations program:

j) When approximately did the hospital inaugurate publication of a bulletin? ———.

(Note: for the purpose of these contests, the word "published" refers to all types of production — printed, mimeographed or other processes — which may be utilized to produce copies of annual reports, bulletins or other materials.)

Send your entries to: MacEachern Contests, c/o HOSPITAL MANAGEMENT, 105 West Adams Street, Chicago 3, Illinois.

The winners of the contests will be announced in HOSPITAL MANAGEMENT following the judging, which will take place in June. ■

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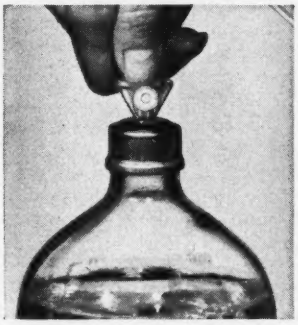

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New Pension Plan for Hospital Employees

Cut Taxes, Aid Savings

by H. H. McFarlin

■ MOST OF US have our worst nightmares at tax time. The complicated forms and maze of tax regulations often seem to be traps, with only a privileged few able to take advantage of so called "loopholes" in the law.

Now, however, just such a "tax avoidance" device, which has the blessings of the Internal Revenue Service, works for full- and part-time employees of specified nonprofit organizations such as hospitals, community chests and educational foundations. This little-publicized device grants broad benefits to hospital employees in every salary range.

The Code provision (Sec. 403b) enacted in 1958 informally may be called the "Tax Sheltered Annuity Law." It allows many hospital employees, and certain other preferred groups, to place in an annuity pension plan up to 20 percent of their income a year for each year of service, without paying taxes on this portion of their income. Payments under the annuity contracts ultimately are taxed, but usually at a lower rate many years later. Thus, the tax sheltered annuity law provides a type of averaging device whereby income earned during the peak of one's productive years may be deferred and taxed during one's unproductive years.

Any authorized underwriter can provide this type of annuity contract. The plans are worked out on an individual basis and are adaptable to changing financial circumstances. Under the plan, savings also accumulate interest.

Ordinarily the primary purpose of an annuity is to build up a substantial fund for retirement, whenever that may be. However, these particular annuities may be purchased in such a way as to increase not only benefits available many years from now but greatly increasing cash presently available. This is done by purchasing an annuity with a substantial cash surrender value. This cash value may be as much as 90 percent of the original purchase price even if surrendered immediately after purchase. Thus, for emergencies, or during periods of diminished earnings, the accumulated funds can be made available. Funds received at these times would be subject to income tax, but the rate of taxation probably would be lower because of decreased earning capacity.

It is not possible in a short article to answer all the questions that come to mind about the tax advantages of such annuities. There are too many variables to be considered. How the program can be adapted to a particular set of circumstances must be left to personal consultation. Each qualified organization and employees should look further into the matter at the earliest opportunity.

Here are some examples of the way the annuity law can provide additional financial security, to a large number of hospital employees.

Example No. 1

Dr. John Jones is the administrator of Dearborn Hospital which is classified as a charitable organization under Code Section 501 (C) (3). He now is 60 years old and has been an employee of the hospital for 15 years. He has a taxable income of $15,000 a year. Dr. Jones plans to retire in five years.

Since he is not pressed for "spendable income," he decides to put $3,000 of his salary every year into his annuity plan. He persuades the hospital to take $3,000 of his salary and purchase for him an annuity policy having many settlement options, one of which is a generous cash surrender value. (The various settlement options give greater flexibility and liquidity to his investment.)

Dr. Jones' benefits are as follows:

1. He begins accumulating a ready source of emergency funds.
2. He has deferred paying income taxes on the top $3,000 of his income for the current year, thereby saving 30 per cent or $900 in income taxes for the first year.
3. If Dr. Jones decides to wait until after age 65 to retire, he may pay no income tax at all on the proceeds of the annuity. This is because at that time increased exemptions will more than adsorb any taxable income from the proceeds of the annuity.
4. Should Dr. Jones retire sooner, and cash in his annuities over several years, chances are the tax rate on the proceeds will be much less than if the purchase price of the annuity had been taxed in the year of purchase.

Example No. 2

Dr. Smith has served as a department head at Dearborn Hospital for eight years. He is 40 and earns $50,000 a year. He needs $20,000 before taxes in "spendable income" a year and thus can put $30,000 into an annuity. He has not decided when to retire but persuades the hospital to purchase an annuity plan for him. The maximum tax-free annuity allowed is computed as follows:

Contributions cannot exceed 20 percent of the employee's current includible compensation ($20,000),

Please turn to page 55

Mr. McFarlin is president, Universal Pension Company, Inc., Riverdale, Maryland.

McFarland

Continued from page 52

multiplied by his years of service (8), minus total tax exempt premiums of prior years (none since Dr. Smith is just beginning his annuity plan). The maximum tax free annuity allowed for Dr. Smith works out to $32,000. Since he wants to put in only $30,000, he is able to receive a tax exemption on the entire sum. Following the steps in example 1, we see that Dr. Smith would benefit in all the same ways except that *his* tax saving for the current year would be $15,020. In subsequent years his maximum tax free contribution would decrease because of the factor of deducting his total tax exempt premiums of prior years. But Dr. Smith's tax free allowance would never go below $8,334 per year, with a minimal tax saving each year of $4,417.

Example No. 3

Joe Doe, 35, is the chief accountant for Dearborn and earns $7,500 a year. Since he has several children, he needs a rather high "spendable income" in relation to earnings. The hospital wants to recognize his meritorious services by giving him a choice of a $500 raise or the purchase by them of a retirement annuity of $500 per year.

Since Joe can get along on his salary, he wants to put his raise into savings. Choices available are a bank account, life insurance with a cash surrender value, U.S. Savings Bonds, or a tax free retirement annuity. When computing his "after tax available cash," Joe finds that interest on a savings account or U.S. Bonds is highest, lowest on life insurance, with his retirement annuity falling in between.

However, the retirement annuity draws interest on the *whole* amount of the raise before taxes ($500) while the alternatives give their return only on $400 (the first $100 going for federal taxes). When Joe also discovers that death benefits are a standard inclusion in the retirement policy, he decides that it is the best investment for the future.

Example No. 4

Dr. Carter has been a part-time employee of Dearborn for five years, directing the operations of an afternoon clinic. His salary is $10,000 a year. Since he does not work full time at the hospital, the law requires that the computation of his tax free annuity contribution must be reduced by half. However, Dr. Carter still can take advantage of the tax free benefits.

He decides to keep approximately two-thirds of his hospital salary $6,666.67. Using the formula noted in example 2 and reducing the total by one half, we see that Dr. Carter can obtain full tax free benefits on the remaining one-third ($3,333.33) of his income at the hospital that he wants to contribute to the annuity plan. And he also saves approximately $866.66 in federal income taxes by putting one-third of his part time salary into a retirement fund.

In conclusion, as may be seen from the foregoing examples, the advantages of the tax exempt annuity purchases may be tremendous. It behooves every administrator and department head to consider his own particular situation. But a word of caution — because of the technicalities of this particular field, no program should be undertaken without thorough consultation with the hospital's certified public accountant and legal counsel. ■

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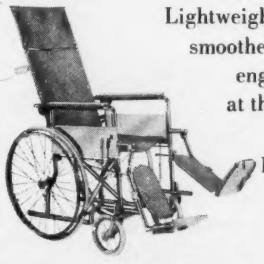

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BOOKS

American Board of Legal Medicine (collected papers)

published by Central Book Company, Inc., New York. pp. 238. $10.00

■ This is an excellent group of assorted scientific papers attacking a variety of medico-legal subjects. The medico-legal aspects of prenatal injury, senility, drunk driving, personal injuries and public health problems are well covered by authorities in their fields. The book also covers trends in hospital liability, medico-legal aspects of blood, sex, artificial insemination, suicide and various types of surgery. Among the authorities contributing to this book are Alfred Koerner, Sidney Franklin, Thomas Slattery, Reuben M. Dicker, Louis J. Gelber and Jacob Reiss all of whom have degrees in medicine and in law. The American Board of Legal Medicine has for its objective the consideration of any legal matter or contest involving medicine. This book would be especially useful for hospital attorneys and legal practitioners who specialize in medical and hospital problems. C.U.L. ■

Decision Making in Hospital Administration and Medical Care

By James A Hamilton, Director and Professor, Program in Hospital Administration, School of Public Health. University of Minnesota Press, Minneapolis, Minnesota. 1960 pp 710 $10.50

■ THIS IS A RATHER comprehensive casebook prepared by an acknowledged master and authority on hospital administration. Professor Hamilton has prepared a very useful teaching instrument for seminar work in formal or informal educational experiences. Methods of developing and isolating problems are illustrated by indirection.

The problems, many of which are taken from the author's own experience, are well stated and certain pertinent questions are asked as to what the student would do under the circumstances.

No answers are provided and the book is evidently not meant to serve as an authoritative work on hospitals. It is strictly a teaching instrument which has been designed to meet the need for authentic cases to be used as teaching instruments.

In the hands of the author these cases can be vivified because of personal knowledge of them. In the hands of strangers there is a danger that they might become lifeless and meaningless. The reader who has his own means of conjuring up visions suggested by the written word, might portray in his own mind a totally different situation then that intended by Mr. Hamilton. But this is a handicap of any casebook and this one has been particularly well written and so should reduce this drawback to a minimum.

Everyone who teaches hospital administration should use this volume and everyone who is studying hospital administration as a career should learn it thoroughly.

For the practicing administrator in the field, the book has academic importance but still makes interesting reading. It might even raise the morale of the administrator who is beset by problems, when he reads what could happen and has happened elsewhere. C.U.L. ■

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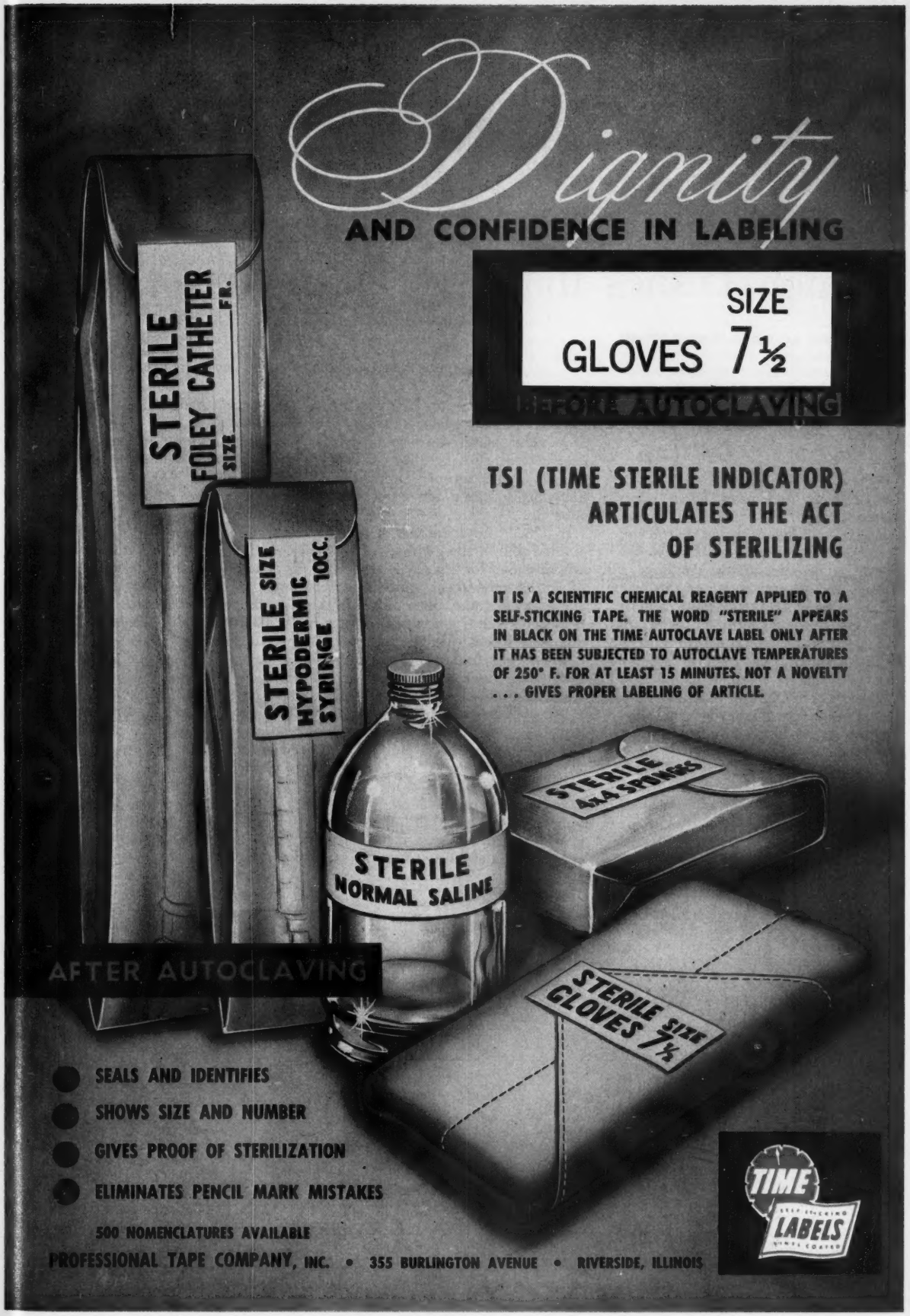

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food & dietetics

Sister Brigid, C.S.A.

Lenten Dishes that Are Different

Olives can be more than a relish

by Ilma Lucas Dolan
Dietitian
California Foods Research Institute

■ IN LONG AGO DAYS when olive trees graced the gardens of Gesthemane, no one dreamed that in the twentieth century ripe olives would come in number 10 cans and be a staple in hospital commissaries and store rooms. But dreams have a strange and mysterious way of reaching practical conclusions.

Even centuries before Christ, olives were a symbol of victory. Winners of Olympic games were awarded a coveted crown of olive leaves as an unmistakable mark of victory!

Familiar to everyone is the heart-warming story of the dove returning to Noah's Ark with an olive branch. Long ago days, indeed!

In the Mediterranean area where ripe olives have flourished for many centuries, the fruit is not allowed to ripen fully because it becomes infested with an insect called the "olive fly." Here the fruit is necessarily picked green to save the crop from being destroyed by the destructive fly. In our country, things are different, happily. We have been spared the curse of the olive fly.

In USA, the fruit was originally planted within the confines of western missions for its oil, a vital part of early day meal patterns. But along toward the beginning of the twentieth century, someone happily discovered that ripe olives could be ripened on the tree, cured and canned to make a delectable relish and incomparable recipe ingredient.

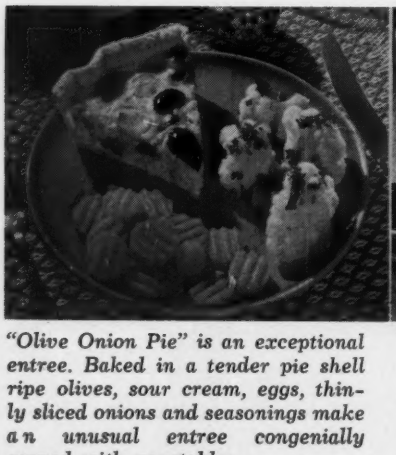
Ripe olives are a unique fruit because of their fruit oil content. Only one other fruit has a similar characteristic and that's the avocado.* Ripe olives average a little better than 17 percent olive oil. It is this oil with its inimitable flavor that gives the fruit its fine taste, its exceptional palatability. The oil is in an emulsified form and is readily digestible.

Of course, ripe olives have other singular and worthy qualities. They contain pro vitamin A, ascorbic acid, niacin, riboflavin, folic acid, vitamin B_6, vitamin B_{12} and thiamine, together with 11 minerals including some likely to be lacking or at least low in American dietries — phosphorus, calcium, iron, copper and a trace of cobalt.

Dietitians are sometimes likely to consider ripe olives in terms of a relish. They are and they are a delicious one. But they are much more than that. Ripe olives are an excellent ingredient in a recipe and have the happy faculty of imparting their fine but delicate flavor of olive oil throughout whatever preparation in which it may appear.

Ripe olives come in many sizes. Some dietitians find this confusing; others find it extremely practical. Every label on every container of ripe olives carries a vignette illustrating the exact size of the fruit on the can and the approximate num-

*See Hospital Management, March 1960, p. 74-75.

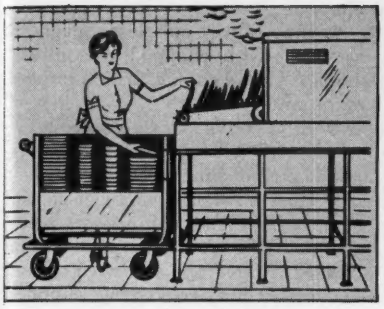


"Olive Onion Pie" is an exceptional entree. Baked in a tender pie shell ripe olives, sour cream, eggs, thinly sliced onions and seasonings make an unusual entree congenially served with vegetables.

"Eggs Vienna"—for staff or volunteers' brunch. On toasted English muffins go Vienna sausages and poached eggs garnished with a sauce of condensed mushroom soup, sour cream and pieces of ripe olives.

"Quick Tomato Aspic" goes well with sandwiches, soups or entrees. Lemon flavored gelatin, tomato juice, sliced celery and wedges of ripe olives are the well-chosen ingredients which bring approval.

Cut your dish and tray handling costs with flexibility like this



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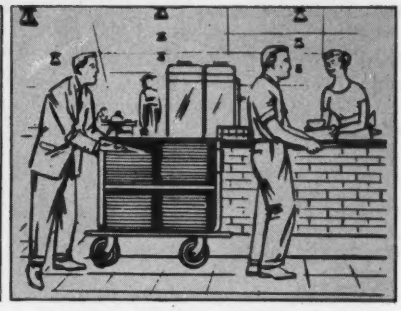

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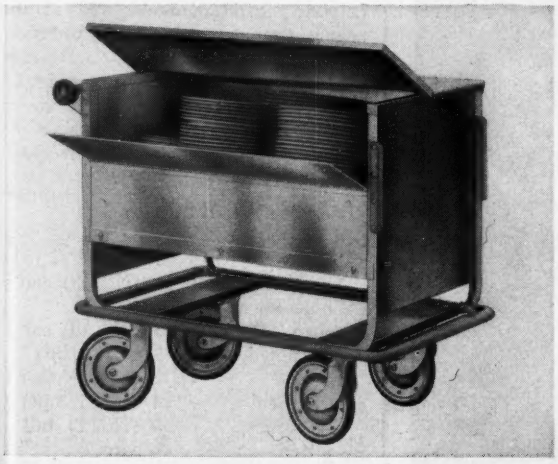
Priced to fit any budget . . . from utility Model 405 to the deluxe Imperial 707 with hinged front and top cover for enclosed sanitary protection. All three models are sturdily constructed of finest satiny-finish stainless steel. Reinforced at every point of stress to withstand rugged use . . . provide years of dependable performance.

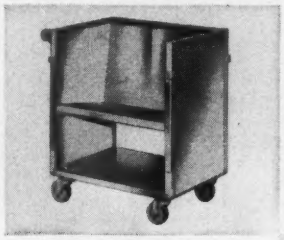
Perfectly balanced for finger-tip handling . . . even with heavy loads. Heavy-duty, high tolerance, all-swivel casters glide easily, silently over the roughest floors. Full bumper protection.

Big capacity . . . yet compact for maximum convenience and utility. Flexible use — stores and distributes dishes or trays . . . transports heavy, bulky items like milk cases, crates of produce or canned goods. Models 405 and 407 feature extra capacity on lower shelf.

No space-wasting compartments or dividers. One-side workability eliminates reaching, stretching, bending . . . unnecessary turning of cart. Any of these Lakeside trucks can make dish handling easier, speedier — almost effortless!

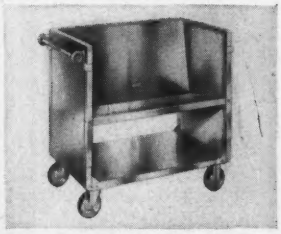


Model Imperial 707
$275.00



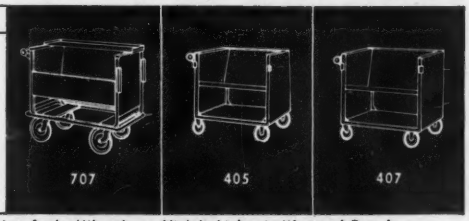
Model 405
$93.75

Model 407
$123.50



Available Through All Leading Institutional Food Service Equipment Dealers

Specifications	707	405	407
Shelf Size	18½ x 32"	15½ x 27"	20 x 35"
Over-all Size	24 x 39¾ x 32½"	19¼ x 30½ x 32"	23 x 38¼ x 32"
Number of Shelves	1	2	2
Clearance Between Shelves	None	7½"	6"
Diameter of Caster	8" All Swivel	4" All Swivel	5" All Swivel
Carrying Capacity	500 lbs. 15 doz. 9" plates and 6 doz. 7" plates or 5 doz. 14 x 18" trays	400 lbs. 15 doz. 9" plates or 3 doz. 14 x 18" trays	400 lbs. 15 doz. 9" plates and 6 doz. 7" plates of 5 doz. 14 x 18" trays
Shipping Weight	136 lbs.	50 lbs.	90 lbs.



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ber of pieces of fruit in the can — thus there should be no confusion either as to the size of the fruit or the number of pieces.

For the convenience of hospital food services small and large, ripe olives come packed whole, pitted, chopped and sliced. This eliminates troublesome labor costs. Whatever the form, ripe olive flavor is always at its best. Ripe olives have sometimes been referred to as the poor man's mushroom; it may be used in so many similar and satisfactory ways.

The uses of ripe olives in food preparation are too numerous to mention, but they are particularly popular and delectable in:

- Cream of tomato soup with slices of ripe olives
- Clear chicken broth with slices of ripe olives
- Ripe olive cocktail—with dessert grapefruit sections, sliced celery and cocktail sauce
- Ripe olive cocktail—with crab and cubes of avocado
- Ripe olive gelatin salad — with lime-flavored gelatin, ripe olive wedges and shrimp with thousand island dressing
- Ripe olive chicken or turkey salad — with sliced ripe olives, chicken and toasted diced roasted almonds
- Ripe olive meatless spaghetti sauce — with chopped ripe olives, tomato, grated cheese, instant minced onion and spaghetti
- Ripe olive rice casserole — whole ripe olives, rice, seasonings, milk, grated sharp cheese, eggs
- Ripe olive ham sandwich spread — ground ham or luncheon meat, chopped ripe olives, chopped celery
- Ripe olive egg sandwich spread — chopped hard-cooked egg, chopped ripe olives, grated raw carrot
- Ripe olive corn bread stuffing — sliced ripe olives, corn bread, seasonings, broth.
- Ripe olive souffle — whole ripe olives, egg, bread crumbs, cheese, milk.
- Ripe olive rarebit — cheese sauce, ripe olives, instant minced onion

Ripe olives are a garnish and relish par excellence. They dress up salads, entrees, sandwiches, soups and appetizers and look doubly attractive when they are rolled in a few drops of oil to keep them attractively shiny.

Ripe olives give fascinating variety to hospital meals, and at the same time provide good nutrition, too. ■

Tamale Casserole
24 (8-oz) servings

Ingredients	Amount
Lean beef, ground	4 lb
Olive oil	4 oz (½ c)
Onion, chopped	1 lb 4 oz (2 pt)
Tomatoes	1 (No. 10) can
Whole kernel corn	1 (No. 10) can
Chili powder	½ oz (3 tbsp)
Salt	2 oz (5½ tbsp)
Corn meal	14 oz (1 1/3 pt)
Ripe olives, pitted	3 (No. 1) tall cans
American cheese, grated	1 lb (2 pt)

Brown beef in oil; add onion and cook until wilted.

Stir in tomatoes, drained corn, chili powder and salt and heat to boiling. Slowly stir in corn meal. Cook over very low heat 15 minutes, stirring occasionally.

Stir in drained olives, and turn into flat baking pan or individual casseroles. Sprinkle with cheese.

Bake in moderate oven (350 degrees F.) 30 to 40 minutes in flat baking pan, or 25 to 30 minutes in individual casseroles.

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MILLS AT GRIFFIN, GEORGIA

Mexican Chicken Pie
50 (8-oz) servings
2 steam table pans 12 x 20 or
50 (8-oz) casseroles

Ingredients	Amount
Chicken, cooked and boned	5 lb (5 large fowl)
Chicken broth	5 qt
Salt	1 tbsp
Yellow corn meal	2 lb
Green chilies	4 (4-oz) cans
Ripe olives, pitted	5 (No. 1 tall) cans
Tomatoes	1 (No. 10) can*
Tomato paste	1 (No. 2½) can*
Instant minced onion	2 oz (⅝ c)
Garlic powder	½ tsp
Chili powder	3 tbsp
Salt	1 tbsp
American cheese, grated	1¼ lb

Cut cooked chicken into pieces of 1½ to 2 inches. If desired a 5-lb can of boneless chicken may be used instead of fresh cooked fowl. If canned chicken is used, use canned broth or a chicken soup base for cooking the corn meal.

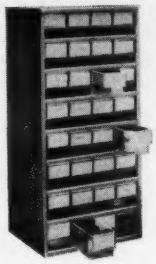
Heat 3 qt of broth to boiling. Combine 2 qt cold broth, 1 tbsp salt and 2 lb corn meal. Mix well and add gradually to the boiling broth. Cook and stir until corn meal thickens. Cover and cook 20 minutes longer over very low heat, stirring occasionally.

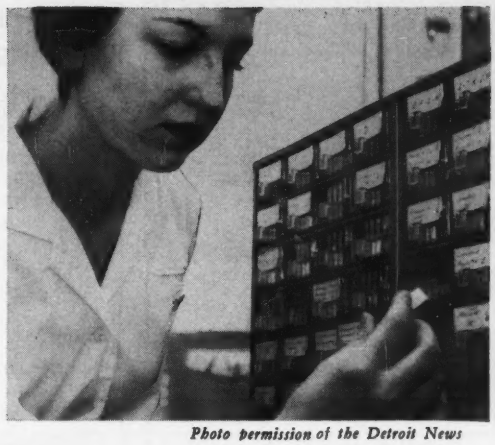
Meanwhile, chop chilies, cut olives into wedges (reserving some whole for garnish) and grate the cheese. In a sauce pan combine tomatoes, tomato paste, instant minced onion, garlic powder, chilies, chili powder and 1 tbsp salt. Simmer 20 minutes. Remove from heat and add olive wedges. Line the bottoms of 2 steam table pans with cooked corn meal. Add a layer of chicken pieces and one of tomato mixture. Sprinkle with half of cheese. Repeat layers, reserving a little of the corn meal for topping. Bake large pans at 350 degrees F. for 50 minutes. Bake individual pies at 350 degrees F. for 25 minutes. Garnish with whole olives and parsley.

*If desired, reduce tomatoes to 2½ qt and use 2½ pt tomato sauce instead of No. 2½ can tomato paste.

Sheer ignorance or lack of discipline has caused about 25 percent of the nation's population to consume so many calories that they are physically sub-par in health and vitality.
—*Dr. C. Glen King, executive secretary, Nutrition Foundation.*

At Akron City Hospital a drawer is assigned to each patient on the floor.





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Akro-Mils small article storage cabinets can be used in supply rooms, offices, operating and emergency rooms, and nurses stations. Perfect for storing surgical tools, supplies, drugs, office items and other small articles.

CONTENTS ALWAYS NEAT, SANITARY AND VISIBLE

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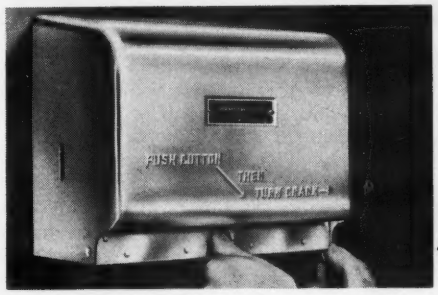
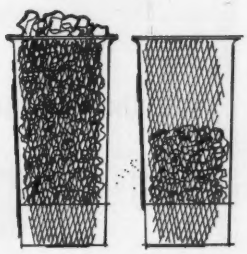
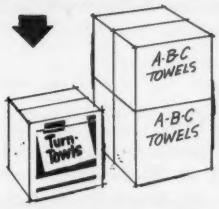




Less Maintenance Cost
Turn-Towl cabinet control cuts towel consumption 50%!



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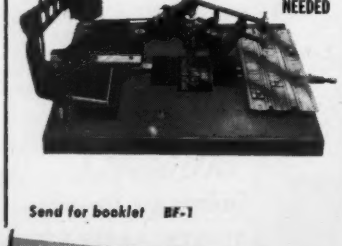

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The Handling and Storing of Fish

■ FISH, being a perishable commodity, should be kept under refrigeration at all times. Only in this way can the quality of fresh fish be maintained. The three primary causes of breakdown in quality of fishery products are (1) bacterial action, (2) oxidation of the oil or fat in the flesh, and (3) enzymic action in the fish.

Temperature and Sanitation

Bacterial action contaminates fishery products when there is poor sanitation in handling and high temperature after the fish have been removed from the water. It is almost entirely arrested when fish are frozen and stored at very low temperatures. It can be considered practically eliminated as long as the fish are kept in this condition.

Oxidation of the oil or fat can cause spoilage of frozen fish even in cold-storage rooms of low temperature. Oxidation is indicated by a yellow discoloration on the surface of the skin or on the flesh in areas exposed to the air. This action is greatly retarded when the fish are properly glazed with a thin coating of ice, or are covered with any of several moisture-vapor-proof wrappings available.

Enzymes responsible for the third type of spoilage are substances in the flesh which build up and tear down the body tissues during the normal life processes. These reactions are common to all forms of animal life and are automatically controlled as long as life is maintained. Although the temperature at which fish are stored has a definite effect on the speed of the digestive reaction of the enzymes after death, the enzymic action cannot be stopped completely during handling and storage. Under good storage conditions, however, the action has no important effect on quality.

Fresh Fish

Fresh fish should be kept constantly below 40 F., and preferably at 31 or 32 F., to ensure maximum storage life. Ice is the best preservative yet devised for keeping fresh fish, since it not only holds the temperature but also keeps the surface of the fish moist and in good condition.

Shipments of fresh fish should be examined immediately upon receipt

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for signs of spoilage and body damage. They should be packed in ice for delivery, and should be well iced when received. Finely crushed ice is preferable to large pieces, as it does not bruise the fish. Fish packed in orderly arrangement hold their natural shape longer and better. Rough handling should be avoided, since bruises and punctures of the flesh induce and hasten breakdown in quality.

Frozen Fish

Frozen fish should be kept solidly frozen until ready for use. Do not refreeze fish that have been thawed. Maximum storage life can be obtained by maintaining a temperature of zero degrees F. or below and by providing adequate moisture-vapor-proof wrapping or glazing. In commercial practice, frozen whole fish, and sometimes dressed fish, are coated with a layer of ice by dipping in cold water after freezing. If fish are placed directly in the refrigerated space without suitable protective treatment, undesirable changes will take place during cold storage: A gradual loss of moisture will occur until the fish are shrunken and dried; this dehydration not only causes an unsightly appearance and alteration in texture, but also results in loss in weight and flavor.

Thawing Frozen Fish

Frozen fish, fillets, and steaks may be cooked as though they were in the unfrozen form, if additional cooking time is allowed. When fish are to be breaded and fried, or stuffed, it is more convenient to thaw them first to make handling easier. Thawing is necessary when whole or drawn fish are to be cleaned or dressed. Methods of thawing fish are as follows:

1. Thawing at refrigerator temperature (40 to 45 F.) is the recommended method. The fish should be held at this temperature only long enough to permit ease in preparation. A one-pound fillet will thaw in about 18 hours.

2. Whole or drawn fish may be thawed by immersing in cold running water. This is the quickest method. Thawing time will vary with size and shape of fish. Fillets and steaks can be thawed in about one-half hour in cold water, but should be removed from the package while being thawed.

3. Thawing at room temperature, although sometimes practiced, is not recommended. In this method, the thinner parts of the fish, such as the section near the tail, thaw faster than other parts and may become subject to spoilage if the thawing period is too long. A one-pound package of fillets takes three or four hours to thaw by this method.

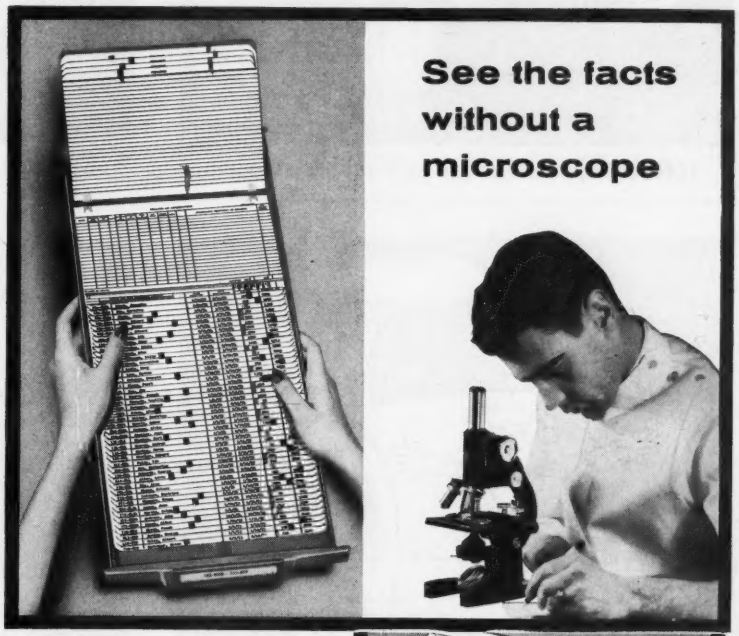
4. Whole or drawn fish may be thawed by being embedded in crushed ice, but this method is much slower than the others.

Shellfish

When storing fresh shellfish, the temperature should be maintained near 32 F. A few degrees higher can cause a considerable loss in quality in a few hours. Shellfish meats, either fresh or cooked, should not be exposed to bacterial contamination.

Frozen shellfish should receive the same care as that given frozen fish. Thawing methods for frozen shellfish are the same as those for frozen fish. ■

—From Fresh and Frozen Fish Buying Manual, Fish and Wildlife Service, U.S. Department of the Interior.



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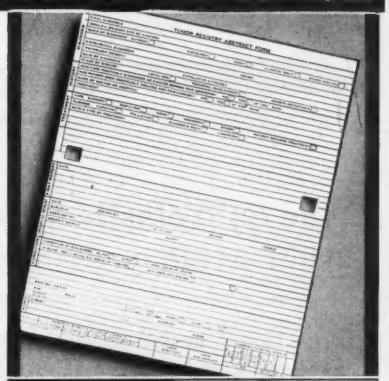

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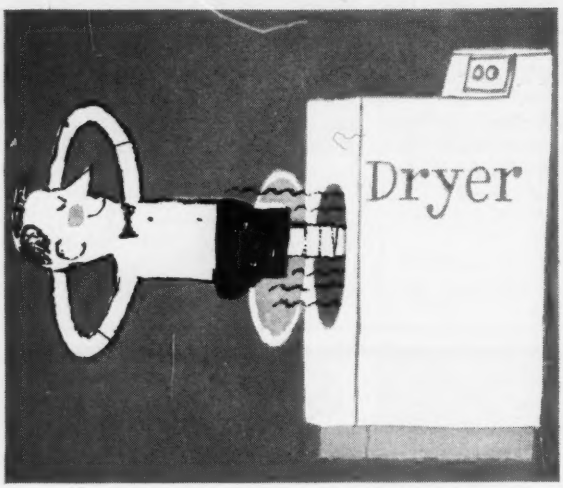

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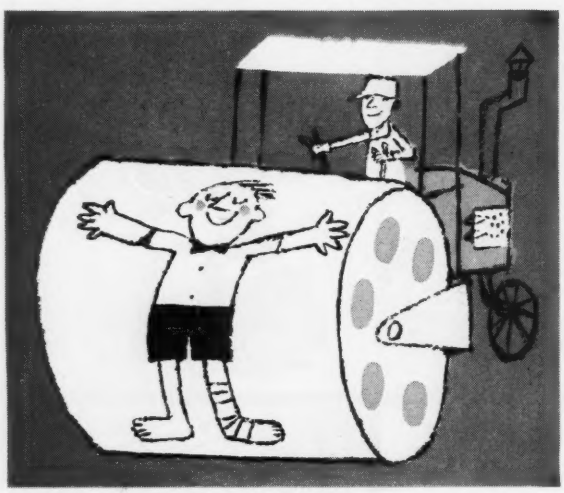

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HOSPITAL MANAGEMENT'S

monthly menus

★ Recipes following

1

Apple raspberry juice
Hot or ready to eat cereal
Crisp bacon
Pecan roll

•

Cranberry coated ham slice
Sweet potato surprise
Buttered carrots and celery
Citrus fruit pinwheel salad
Pompadour pudding

•

Celery soup
Spaghetti with meat sauce
Mixed greens–oil and vinegar dressing
Royal Anne cherries

2

Apricot nectar
Hot or ready to eat cereal
Scrambled egg
Toast

•

Breaded veal cutlet
Riced potatoes
Carrots in cream
Lettuce wedge - French dressing
Peppermint stick ice cream

•

Vegetable soup
Grilled luncheon meat
Baked potato
Tomato slices
Orange chiffon tart

3

Bananas in cream
Hot or ready to eat cereal
Shirred egg
Toast

•

Golden cruster, perch - tartar sauce
Buttered potato balls
Swiss chard
Grated beet salad
Gingerbread cup cake

•

Tomato clam soup
★Mushroom–cheese fondue
Julienne vegetable salad
Pineapple crunch

4

Baked rhubarb
Hot or ready to eat cereal
3 minute egg
Toast

•

Braised short ribs of beef
Browned potatoes
Zucchini, creole
Avocado salad - roquefort dressing
Cranberry bread pudding

•

Mushroom bisque
Pork tenderloin
Whipped potatoes
Fiesta salad
Apple Betty, de luxe

5

Sliced oranges
Hot or ready to eat cereal
Scrambled eggs
Toast

•

Smothered steak
Stuffed baked potato
Cold tomatoes
Lettuce toss
Banana custard cake

•

Cream of parsley soup
French roast
Julienne potatoes
Peach bloom salad
Date torte

6

Applesauce
Hot or ready to eat cereal
Baked egg
Toast

•

Smothered steak
Potato cake
French style green beans
Orange date salad
Pecan bars

•

Chilled fruit juice
Toasted cheese - ham rollup
Cottage potatoes
Tomato–lettuce salad
Fruit compote

7

Apple juice
Hot or ready to eat cereal
Shirred egg
Toast

•

Beef a la mode
Brown potatoes
Diced beets
Fresh fruit salad
Coconut wafers

•

Corn chowder
Canadian bacon
Lima beans and corn
Macedoine salad
Fruit whip - custard sauce

8

Grape nectar
Hot or ready to eat cereal
French toast
Preserves

•

Spanish pork chop
Mashed potatoes
Summer squash
Red and white cabbage salad
Lemon custard in graham cracker crust

•

Bouillon
Ham and cheese turnover
Duchess potatoes
Vegetable salad
Date bar

9

Grape juice
Hot or ready to eat cereal
Omelet
Toast

•

Beef roast
Oven browned potatoes
Summer squash
Beet and egg salad
Norwegian prune pudding

•

Bouillon
Swedish meat balls
Creamed diced potatoes
Mexican salad
Baked custard

10

Pineapple juice
Hot or ready to eat cereal
Scrambled egg
Toast

•

Baked trout
Parsley buttered potatoes
Fresh spinach mound
Orange endive salad
Heart shaped raspberry gelatine
Sugar cookies

•

Lentil soup
★Egg croquettes with celery soup
Fruit salad
Grapenut custard

11

Pineapple tidbits
Hot or ready to eat cereal
Curry scrambled egg
Toast

•

Yankee pot roast
Golden brown potatoes
Sauteed okra
Tomato escarole salad
Peach nut custard

•

Vegetable soup
Stuffed green pepper
Cubed carrots
Citrus fruit salad
Silver cup cake

12

Frozen berries
Hot or ready to eat cereal
Bacon curls
Walnut coffee cake

•

Braised sirloin tips - mushroom sauce
Potato cakes
Buttered broccoli
Chutney relish
Strawberry ice cream

•

Noodle soup
Tongue and cheese sandwich
Potato sticks
Frozen fruit salad
Ginger thins

13

Grapefruit half
Hot or ready to eat cereal
Griddle cakes
Syrup

•

Calves liver with bacon
Delmonico potatoes
Creole celery
Cabbage and carrot slaw
Caramel sponge

•

Swiss potato soup
Hamburg pattie
Cornbread
Tossed salad greens
Rhubarb cream tart

14

Stewed apricots
Hot or ready to eat cereal
3 minute egg
Toast croutons

•

Country style round steak
Potatoes in jackets
Sliced beets in orange sauce
Tossed salad greens
★Apple torte

•

Clear tomato soup
Shepherds' pie
Brussels sprouts
Pickled crabapple salad
Angel food cake

15

Grapefruit half
Hot or ready to eat cereal
Orange coffee cake

•

Baked trout
Mashed potatoes
Hubbard squash
Chiffonade salad
Banana cream pie

•

★Egg a la king
Golden glow salad
Cornflake pudding

16

Sliced bananas
Hot or ready to eat cereal
Poached egg
Toast roll

•

Mock chicken leg
Whipped potatoes
Harvard beets
Celery cabbage
Ice cream sundae

•

French onion soup
Frizzled beef on rusk
Baked Idaho potato
Shredded lettuce - Russian dressing
Cream puff

17

Purple plums
Hot or ready to eat cereal
Buckwheat cakes
Syrup

•

★Perfect tuna casserole
Broccoli
Ambrosia salad
Marmalade Bavarian

•

Alphabet soup
Egg celery sandwiches
Potato sticks
Banana nut salad
Whole peeled apricots

18

Cherry juice
Hot or ready to eat cereal
Bacon curls
Raisin toast

•

Stuffed flank steak
Franconia potatoes
Cauliflower au gratin
Apple-grapefruit pinwheel salad
Rhubarb pudding

•

Bouillon
Meat pie with biscuit topping
Vegetable relish salad
Golden cup cake

19

Orange tidbits
Hot or ready to eat cereal
Oven French toast
Jelly

•

Chicken southern style
Buttered noodles
Fresh green limas
Banana nut salad
Lemon lime sherbet

•

Potato pimiento soup
Salisbury steak
Corn pudding
Indian relish
Blueberry buckle

20

Grapefruit segments
Hot or ready to eat cereal
Scrambled egg
Toast

•

Roast fresh ham
Candied sweet potatoes
Fresh peas
Fruit layer salad
Blackberry pudding

•

Split pea soup
Grilled weiners
Lima bean casserole
Garden salad
Fruit cup

21

Grapefruit sections
Hot or ready to eat cereal
Crisp bacon
Blueberry muffins

•

Roast chicken - gravy
Browned rice
Whole kernel corn
Asparagus–cucumber salad
Frosted strawberry cup

•

Cream of spinach soup
California fruit plate with cottage cheese
Ford hook limas
Pocketbook roll
Chocolate pudding

22

Citrus fruit juice
Hot or ready to eat cereal
Shirred egg
Toast

•

Roast stuffed veal
Parsley buttered potatoes
Peas and carrots
Beet relish salad
Butter pecan ice cream

•

Oxtail soup
Savory meat loaf
Potatoes au gratin
Fresh fruit salad
Ice box pudding

23

Kadota figs
Hot or ready to eat cereal
Link sausage
Toasted English muffin

•

Individual meat pie
Julienne carrots
Orange watercress salad
Raspberry ice

•

Vegetable soup
Cubed steak sandwich
Potato chips
Celery cabbage
Cherry pinwheel - lemon sauce

24

Banana slices
Hot or ready to eat cereal
French toast
Jelly

•

★Baked fish in creole sauce
Cut green beans
Peach half with cottage cheese
Chocolate marshmallow roll

•

Cream of asparagus soup
Hot devilled egg - tomato wedges
Cottage potatoes
Wilted endive
Fruit cocktail

25

Orange juice
Hot or ready to eat cereal
Poached egg
Toast

•

Meat balls - mushroom sauce
Potato cakes
Julienne green beans
Tossed salad greens
Cherry roly–poly

•

Chilled fruit juice
Chicken sandwich au gratin
Dutch potato salad
Broccoli
Apricot whip

26

Baked apple
Hot or ready to eat cereal
Canadian bacon
Danish coffee twist

•

Broiled lamb chop
Mashed potatoes
New whole carrots in cream
Tomato aspic salad
Pineapple ice cream

•

Vegetable soup
Assorted meat and cheese plate
French fried potatoes
Cole slaw
Pear halves

27

Kadota figs
Hot or ready to eat cereal
Poached egg on toast

•

Cushion roast of lamb
Potato souffle
Garden peas
Lettuce - herb dressing
Cherry cobbler

•

Creole soup
Jellied veal loaf
Lattice potatoes
Stuffed celery salad
Butterscotch Charlotte

28

Stewed rhubarb
Hot or ready to eat cereal
Omelet
Toast

•

★Broiled spring chicken with spicy sauce
Mashed potatoes
Cream style corn
Radish roses - celery curls
Refrigerator cheese cake

•

Hot vegetable juice
Cold sliced roast beef
Potato salad
Piccalilli
Old fashioned strawberry shortcake

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Selected Recipes From Preceding Menus

Mushroom Cheese Fondue 50 servings

Ingredients	Measure and Wt
Eggs, separated	30 (34 oz egg white) (22 oz egg yolk)
Cream of mushroom soup	2 cans (3-lb 2-oz size)
Milk	1 soup can
Shredded sharp process cheese	4 qt (4 lb)
Dry mustard	2 tbsp
Soft bread cubes	7 qt (1¾ lb)

Beat egg whites until stiff.

Beat egg yolks until thick; combine with soup, milk, cheese, mustard; blend well.

Add bread cubes; mix thoroughly; fold in beaten egg whites.

Pour into 3 pans (12 by 18 by 2 in) until about ½ full.

Bake in moderate oven (375°) for 1 hr or until surface is dry.

Egg Croquettes and Celery Sauce 50 servings

Ingredients	Measure and Wt
Hard-cooked eggs	4 doz
Fine dry bread crumbs	6 c (24 oz)
Finely chopped onion	1 c (6 oz)
Salt	1 tbsp
Black pepper	dash
Cream of celery soup	3 cans (3-lb 2-oz size)
Milk	1 qt
Minced parsley	½ c (1 oz)

Shell and sieve hard-cooked eggs; mix with 5 c bread crumbs, onion, salt, pepper and 1 can celery soup.

Shape into 100 small croquettes using number 24 scoop.

Roll croquettes in remaining crumbs; fry in deep fat at 350° for about 5 min or until golden brown.

Blend remaining soup with milk and parsley; heat; serve over croquettes (use 2 oz per serving).

Eggs a la King 50 servings

Ingredients	Measure
Hard-cooked eggs	4 doz
Onion	1 small
Green pepper	1½ c (3 small)
Butter	½ c
Medium white sauce	4 qt
Cayenne	dash of
Celery salt	1 tsp
Salt	1 tsp
Pimentos	1½ c
Pitted ripe olives	2 c
Toast	50 slices
Paprika	dash of
Parsley	to garnish

Cut the hard-cooked eggs in ¼ lengthwise.

Chop the onion and green peppers and cook in butter until soft.

Make medium white sauce; add the seasonings and the green pepper, onion and pimentos; cut ripe olives in pieces and add to sauce.

Add the eggs, stirring them in very carefully; heat; serve at once on buttered toast from which crusts have been removed.

Garnish with paprika and parsley.

Perfect Tuna Casserole 50 servings

Ingredients	Measure and Wt
Cream of mushroom soup	2 cans (3-lb 2-oz size)
Milk	1 soup can 5¾ c)
Tuna, drained and flaked	2 qt (4 1-lb cans)
Cooked peas, drained	3 qt
Potato chips, coarsely crushed	2½ qt (20 oz)

Blend mushroom soup with milk; stir in tuna, peas and 2 qt potato chips.

Pour into 2 baking pans (12 by 18 by 2 in); top with remaining chips.

Bake in hot oven (400°) for 30 min.

Baked Fish in Creole Sauce 50 servings

Ingredients	Measure and Wt
Haddock fillets	12 lb
Flour	2 c (8 oz)
Chopped onion	2 c (8 oz)
Chopped green pepper	2 c (8 oz)
Shortening	2 tbsp
Tomato soup	2 cans (3-lb 3-oz size)
Lemons, thinly sliced	2

Cut fish into serving size pieces; lightly coat with flour; arrange in 3 greased baking pans (12 by 18 by 2 in).

Cook onion and green pepper in shortening until tender; blend in soup.

Pour sauce over fish; distribute lemon slices on top.

Bake in moderate oven (375°) for 45 min.

Creamed Salmon and Peas on Toast 50 servings

Ingredients	Measure and Wt
Chopped onion	2 c (9 oz)
Butter or margarine	½ c (4 oz)
Cream of celery soup	2 cans (3-lb 2-oz size)
Milk	1 qt
Flaked salmon, with juice	2 qt (4 1-lb cans)
Cooked peas, drained	2 qt
Toast, buttered	50 slices

Cook onions in butter until tender; blend in celery soup and milk; fold in salmon and peas.

Heat but do not boil.

Serve over buttered toast.

Deviled Crab 50 servings

Ingredients	Measure and Wt
Cream of celery soup	3 cans (3-lb 2-oz size)
Flaked crab meat	6 lb
Bread crumbs	1 qt (1 lb)
Diced green pepper	1½ c (9 oz)
Chopped onion	¾ c (3 oz)
Lemon juice	¾ c (6 oz)
Worcestershire sauce	1/3 c
Prepared mustard	3 tbsp (1½ oz)
Tabasco sauce	dash
Butter or margarine	

Lightly mix all ingredients except butter; pour into 3 baking pans (9 by 12 by 2 in) or individual shells.

Dot top with butter or margarine.

Bake in moderate (350°) oven for 1 hr; bake individual servings 20 min.

Significant Trends in Food Service and Equipment

by Anne C. Donovan

Dietary Consultant
Div. Hospital and Medical Facilities
U.S. Public Health Service

■ INSTITUTIONS today are streamlining their operations for efficient, economical services as labor and equipment costs continue to spiral upward and plague each department.

New developments in labor saving equipment and training techniques are being adopted to offset these cost factors. As a result, significant trends toward greater centralization and automation dominate the scene in the field of institutional food service. These trends, grouped under centralization and automation, continue to emphasize radical changes in the design of equipment. They are:

1. A centralized system for patient tray service and dishwashing.
2. Self-service in cafeteria for patients.
3. Greater automation as a result of an increased use of tailored foods in the preparation area.
4. Increased emphasis on the use of mobile equipment in all areas.

The need of controlling costs and increasing efficiency stresses the necessity of institutions relying on mechanical equipment, and a further exploring of the full potentials of automation and centralization.

Examples of new types of this equipment, designed with these objectives in mind, have created special interest in the development of:

1. Mobile units for preparation, service and dishwashing areas;
2. Mobile serving lines;
3. Automatic timers and thermostatic heat controls built into cooking equipment;
4. Increased use of pressure cooking;
5. Utilizing chemical and mechanical improvement in automatic dishwashing.

Such labor saving equipment is needed to promote and assure an efficient economical food service operation. ■

—From a presentation at the annual meeting, American Dietetic Association, Cleveland.

■ OPINION RESEARCH CORP. of Princeton interviewed nearly 500 workers to test their reaction to certain words management often uses. "Employee benefits" meant something to 82 percent of those interviewed, but only 54 percent understood "fringe benefits". Only 54 percent knew the meaning of mass production (one worker said it was "producing more than the buyers can absorb"). "Corporation" carried overtones of money, power and selfishness; "company" drew a more favorable response. Survey also found that only 12 percent of the workers read and understand the average article in the company publication. ■

— Newsletter, Industrial Psychology, Inc.

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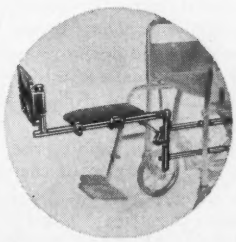

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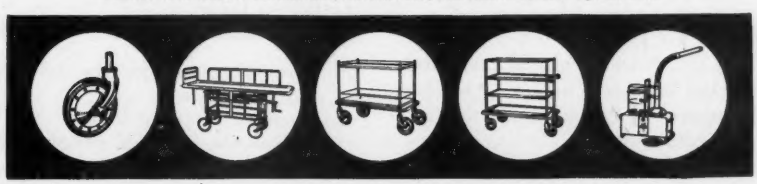

pharmacy

by Daniel F. Moravec, M.Sc.

Editor's Note: It is well established that HOSPITAL MANAGEMENT feels a keen responsibility to its readers to report ideas, devices and procedures that may improve patient care in hospitals. It is the responsibility of this Pharmacy Section of HOSPITAL MANAGEMENT to present the pharmaceutical aspects of such contemporary advances and to comment on them when and if the occasion demands.

In the July and August, 1957 issues of HOSPITAL MANAGEMENT, this section presented the *Cardiac Emergency Kit* by Dr. C. K. Elliott. This article provided a complete list of accepted cardiac drugs for use when speed in treatment could determine whether a patient may live or die. Since the printing of this article changes in drugs have come about and, because of the widespread interest shown both domestic and foreign, a revision of the *Cardiac Kit* article will be in this section in a future issue.

Now we have a very useful and again perhaps a life-saving memorandum concerning *antidotes* and *supplies* that are of good value to have in the hospital emergency room when a patient who has been poisoned is brought in for treatment. This memorandum is intended to be a **guide** to hospital pharmacists in establishing a useful and readily available antidote section in their hospitals.

The antidote section or poison control center is generally most wisely placed in the emergency room of the hospital. However, there may be some instances where the center would best be situated in the hospital pharmacy, especially if the pharmacy dispensary is located next to or very near the emergency room. In such cases, duplicate drug and reference stocks would be avoided but still readily available to the emergency room. Whichever the case, the antidote supply should all be *complete in one area,* and not half in the pharmacy and half in the emergency room.

Ideally, all should be located in the same section of the same room. A cabinet should be provided to house the drugs, supplies, references and equipment with all clearly labeled and marked so that physicians and nurses can easily reach what they want when needed.

We are grateful to Dr. Christian and the Poison Control Committee of the Illinois Chapter, American Academy of Pediatrics for this material.

DFM ■

Antidote Supplies for the Emergency Room

1961 *Memorandum*

TO: Hospital Administrators and Hospital Pharmacists

FROM: Joseph R. Christian, M.D.
Chairman
Poison Control Committee
Illinois Chapter
American Academy of Pediatrics

RE: Antidote Supplies Essential for the Emergency Room

A. For unknown poisons: the Universal Antidote

Powdered Charcoal (burned toast) — 2 parts

Magnesium oxide (milk of magnesia) — 1 part

Tannic acid (strong tea) — 1 part

B. Home remedies for the following substances:

1. *Iodine*: Flour or starch

2. Alkaloids, such as atropine or morphine: strong tea, dilute tincture of iodine solution (15 drops in ½ glass of water), or weak tannic acid.

3. *Heavy metals:* milk and eggs to provide protein to precipitate the poison.

4. *Central Nervous System Depressants:* (i.e. barbiturates or alcohol — strong coffee or tea for stimulation.

5. *Corrosives:* oils

6. *Acids:* Sodium bicarbonate,

milk of magnesia, chalk, soap and water.

7. *Alkali:* Lemon water or citrus fruit juice, vinegar.

C. Specific Medications:

1. ACTH
2. Alcohol, ethyl
3. Aminophylline for intramuscular and intravenous use
4. Amyl nitrite perles
5. Animal Charcoal (to prepare Universal Antidote)
6. Aromatic spirits of ammonia
7. Atropine sulfate
8. BAL in oil
9. Caffeine sodium benzoate for intravenous use
10. Calcium gluconate 10% for intravenous use
11. Calcium disodium edathamil
12. Chloral Hydrate
13. Chloroform
14. Cortisone
15. Dextrose in water 50% for intravenous use (20 cc. vials)
16. Digitalis preparations for intravenous and intramuscular use
17. Ephedrine sulfate for oral use
18. Epinephrine 1:1000
19. Ether
20. Hydrochloric acid 0.5% or vinegar 1:4
21. Hydrocortisone
22. Magnesium oxide (to prepare Universal Antidote)
23. Magnesium sulfate 50% solution for intravenous use
24. Megimide (Bemegride-Abbott)
25. Metacorten (Prednisone-Schering)
26. Methylene Blue 1% 50 cc ampules
27. Metrazol 25% solution (Pentylenetetrazol-Knoll)
28. Nalline (Nalorphine-Merck Sharp & Dohme)
29. Nor-epinephrine
30. Oxygen
31. Paraldehyde
32. Pentobarbital (Nembutal-Abbott)
33. Pentothal sodium for intravenous use (Thiopental Sodium-Abbott)
34. Picrotoxin
35. Plasma, lyophilized and irradiated
36. Potassium permanganate, 3 gr.
37. Prostigmine Methylsulfate 1:2000, 1:4000 (Neostigmine Methylsulfate-Roche)
38. Sodium amytal for intravenous use (Amobarbital Sodium-Lilly)
39. Sodium bicarbonate
40. Sodium chloride (physiologic) solution
41. Sodium formaldehyde sulfoxalate, 10 gm. (make 5-10% solution; freshly made is excellent for lavage in mercury poisoning. Use 250 cc. for lavage and leave 100-200 cc. in stomach after lavage)
42. Sodium thiosulfate, 10%
43. Starch
44. Tannic acid (to prepare Universal Antidote)

D. Supplies:

1. Catheters and stomach tubes of various sizes.
2. Syringes 50 cc.; 20 cc.; 10 cc.; 5 cc.; and 2 cc.
3. Needles, hypodermic and intravenous
4. Mouth gag
5. Restraint sheets, blankets
6. Emesis basins
7. Containers for storage of aspirated gastric contents.
8. Poison report forms
9. Reference material:
   a) Physician's Desk Reference
   b) Nelson's "Textbook of Pediatrics" — Sixth Edition
   c) DeSanctis and Varga's "Handbook of Pediatric Medi-

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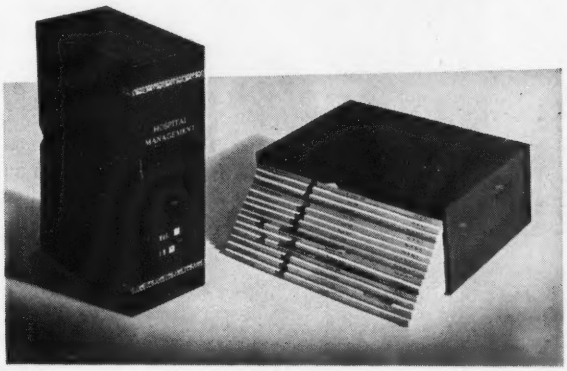

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cal Emergencies" — 2nd Edition

d) Dreisbach's "Handbook of Poisons" — (Lange Medical Publications, Los Altos, California)

e) Press's "Accidental Poisoning in Children" — American Academy of Pediatrics

f) Goodman and Gilman's "Textbook of Pharmacology"

g) Gleason, Gosselin & Hodge — "Clinical Toxicology of Commercial Poisons" (Williams and Wilkins)

E. Desirable Equipment:

1. Tracheotomy set
2. Suction machine
3. Resuscitator
4. Laryngoscope and endotracheal tubes
5. Thoracotomy tray
6. Spinal tray

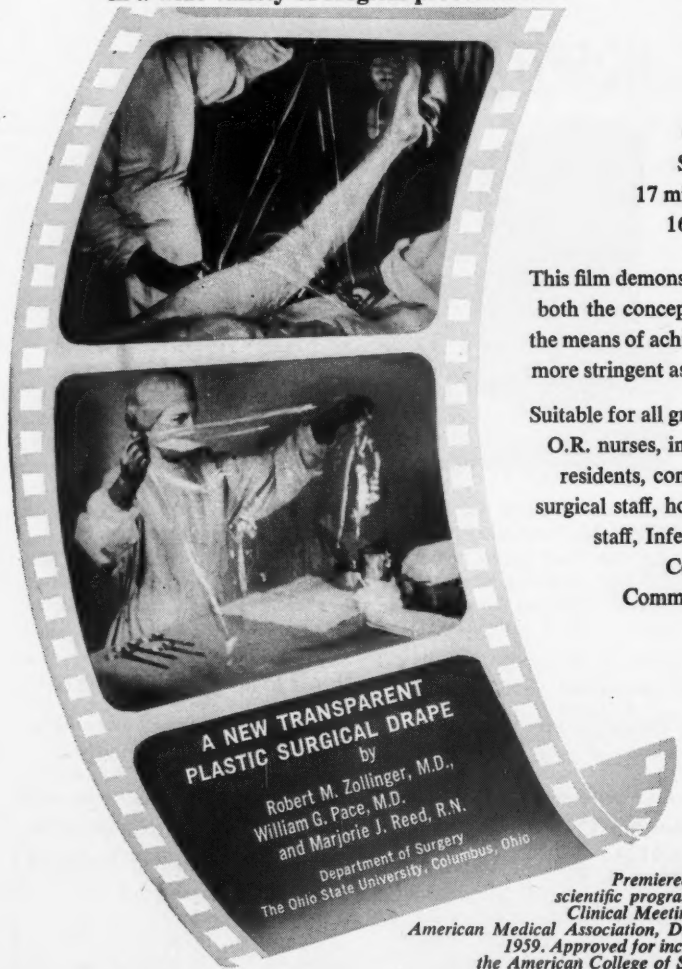
■

Overhead at the Club

". . . and he doesn't really know one end of a virus from the other."

New Technic in Surgical Asepsis...

Motion picture now available showing the technic for isolating the operative wound from the patient's own skin in a wide variety of surgical procedures.



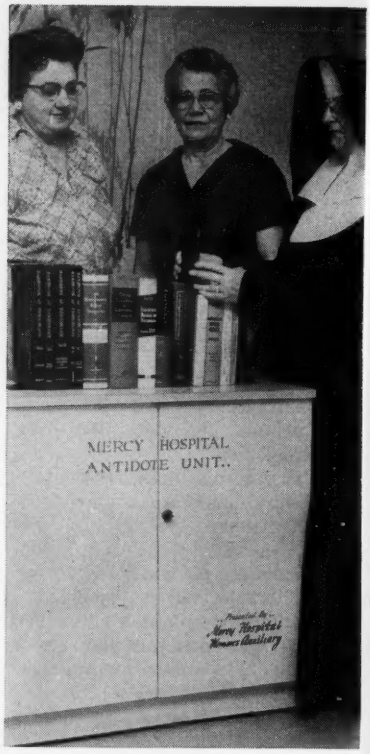
Color
Sound
17 minutes
16 mm.

This film demonstrates both the concept and the means of achieving more stringent asepsis.

Suitable for all groups: O.R. nurses, interns, residents, complete surgical staff, hospital staff, Infections Control Committees.

Premiered on the scientific program of the Clinical Meeting of the American Medical Association, December, 1959. Approved for inclusion on the American College of Surgeons' list of approved films.

To schedule a showing, send requests to the Aeroplast Corporation, Station A—Box 1, Dayton 3, Ohio. Please mention a preferred and an alternate date. Would you also like to show a 16 mm., color and sound, film on the use of spray-on plastic surgical dressing? This is available for showing with the above film, or separately, if you prefer.



Poison-antidote unit

■ A poison-antidote unit presented to Mercy Hospital, Cedar Rapids, Iowa, by the Women's Auxiliary included reference books and a complete set of antidotes which were assembled by the pharmacy department with funds donated by the auxiliary. The presentation was made by Mrs. Edward Kuba, president, and Mrs. F. C. Anderle to Sister Mary Maura, Administrator. ■

Help and Comfort

Compiled and edited by Rabbi M. A. Gutstein and Rabbi Ralph Simon in collaboration with Rabbi David Graubart and Rabbi Irving Melamed. The Chaplaincy Service of The Jewish Federation of Metropolitan Chicago and the Chicago Board of Rabbis, Chicago, Illinois. 1960 pp 56

■ A FIFTY-SIX PAGE booklet of Jewish prayers, several of which are written in Hebrew and English. Prayers for health and comfort, prayers for the year's cycle, and selected verses from the psalms are the three major groupings. Also included are brief explanations and meditations for the major Jewish holidays.

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M.U. ■

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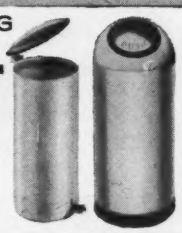

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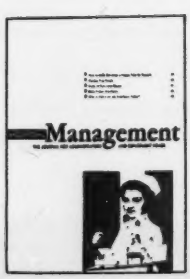

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Photographic Billing

Saves time and space

by Ross E. Godard

Business Administrator
Physicians and Surgeons Hospital
Portland, Oregon

TWO BASIC METHODS for accumulating patient charges—namely, the requisition system and the chart system—are recognized by hospitals today. Basically, they deal with the accumlation of patients' charges and the preparation of the patients' bills. While these may vary somewhat in detail, the results are the same in that a charge is described on the patients' bill.

As its name implies, the requisition system requires that the nurse prepare a requisition. It shows the patient's name and case history number and calls for medications, patient's supplies, or special services as indicated on the doctor's order sheet. The requisition is sent to the service department and is the authorization for that department to issue the supplies.

A copy of the requisition, as a rule, serves as a charge slip. It is priced by the department and forwarded to the business office. This is a very important point because no one is better qualified than the surgery supervisor to know what a patient should be charged for a surgery procedure. Especially is this true if it is an involved case and considerable supplies and materials are required over the normal amount figured in the basic rate for surgery. The business office copy becomes the posting medium for charging these particular items to the patient's account. The items are further substantiated by the doctor's orders which have been written on the patient's chart.

Chart System for Smaller Hospitals

The chart system is the other basic method for accumulating charges to patients. This procedure usually requires that the patient's bill be sent to the business office at the end of each week or when the patient is discharged, whichever occurs first.

In some hospitals these charges are accumulated daily from the charts. A clerk in the business office computes the charges from the nurses' notes which indicate the medication and supplies used and other services rendered. The chart system, however, is normally used in very small hospitals. It cannot be adapted for photographic billing with microfilming because of the technical and confidential nature of the chart itself.

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geons Hospital in Portland, Oregon, installed the requisition system. The requisition serves as a charge slip. It is priced by the service department and then forwarded to the business office where it becomes the charge medium for posting the patient's account.

Microfilming Saves Time

With the photographic method of billing, the patient receives a bill in the form of a slip of paper (6¼ by 3 inches) containing name, address, case, room number with a total of charge slips. The actual charge items are attached to the bill as it is delivered to the patient, who can then check the amounts against the totals on the statement.

Microfilm replaces the daily or weekly itemized posting to patients' statements, thus saving time, typing and duplication of effort in the billing department.

Here is how the system operates:

1. The charges come to the business office from each department in duplicate.
2. The original charge slip becomes part of the patient's bill.
3. The duplicate charge sheet is used for the department earnings record and control.
4. Each department is designated by a different colored charge slip, as well as the department name at the top of the slip.
5. As the charge slips come into the business office they are filed behind each patient's control card.
6. The control card provides space to list the information shown on the completed statement. It becomes the posting medium for room rates, as well as the business office's record card of the patients in the hospital.
7. When the patient checks out, or at the end of the week, whichever is first, the charge slips are removed from behind the control card. The room rate is computed on a tape run on the charge slips. The total of these charges and of the computed room rate is entered on both the control card and the statement.
8. The statement and charge slips are photographed and the statement is delivered or mailed to the patient. If the patient is a member of the Blue Cross or of a similar service, the bill may be mailed directly to the service address.
9. The control card remains in the file until the following morning. At that time all discharges are balanced and the card routed to the bookkeeper for posting to the patient ledger accounts.
10. The microfilm becomes the permanent record of all details of the charges making up a patient's statement.

Reduces File Space

The small space required by the microfilm records is a byproduct of the photographic billing system. In Physicians and Surgeons Hospital the past eight years of the billing detail in film form occupies only a part of one shelf in the safe. There is still space for about five more years on the same shelf.

The simplicity of the microfilm method of billing patients with original requisitons at Physicians and Surgeons Hospital requires only two girls working 40 hours per week to operate the system. They handle all of the bookkeeping for over 6,000 inpatients, and 6,000 outpatients annually. Their work also includes the bookkeeping involved in earnings control, journaling, insurance posting and balancing. ■

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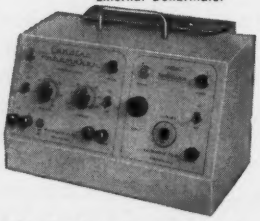

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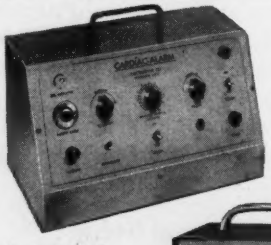

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NAHCSP NEWSLETTER

Official newsletter of the National Association of Hospital Central Service Personnel

Qualities of a Leader

by Lynn R. Timmons

Department Training Director
State of Ohio
Department of Mental Hygiene
and Correction

The job of an administrator or supervisor is to provide leadership. He does this by working with the men and women under his charge in such a way as to get their cooperation in accomplishing the task at hand. To get things done, the administrator or supervisor must spend a major portion of his or her time dealing with people, and this is accomplished through exercising qualities of good leadership. We might say that a major purpose of supervision is to—first, develop and direct people and second, to direct things.

A study conducted some time ago by the National Research Council revealed that leadership is the most important single determiner of morale and performance. Every enterprise in life is concerned with leadership exerted by persons who influence us and direct us toward desirable and, unfortunately, sometimes toward undesirable goals.

Leadership is defined as the activity of influencing people to strive willingly to mutual objectives. The desired paths to be followed are made known to the follower by the leader's exemplary conduct and by suggesting "Follow me," instead of pushing the follower into the desired activity.

Qualities of Good Leadership

1. *Responsible*—has a sense of responsibility for getting work accomplished and achieving harmonious human relations.

2. *Energetic*—has both mental and physical energy, stamina to see things through.

3. *Stable*—has developed emotional maturity or self-control. Is well adjusted.

4. *Understanding*—has understanding of people and their relationships to each other.

5. *Competent*—has knowledge of all immediate operations under him.

6. *Many interests*—has an inquiring mind and well-rounded interests and activities.

7. *Teacher*—has developed teaching skill.

8. *Personally motivated*—has personal desire for leadership and strong motivation to accomplish something.

9. *Communicative*—is able to talk and write clearly and forcefully.

10. *Decisive*—has ability to make decisions promptly.

11. *Intelligent*—has intelligence equal to or greater than followers.

12. *Trustworthy*—has a fine sense of ethics, justice and rightness with readiness to apply to own conduct.

13. *Enthusiastic*—has ardent zeal for performance of duties.

14. *Confident*—has confidence in ability to do the job.

15. *Manager*—has a knowledge of management functions and follows them.

Leadership Developed

Any theory that leadership is inherited, that leaders are born and not developed, must be rejected although a leader must possess certain innate capacities, for example, intelligence. Any individual possessing the necessary capacities, no matter how inexperienced, can become acquainted with the component elements of leadership. An individual must know his strong and weak traits, and he must capitalize on his strong traits and strive to improve his weak ones.

Good Leadership is Necessary

Competent leadership is needed at all levels of management. Contrary to popular opinion, leadership is not confined to top management positions, but is equally necessary at lower levels, especially the supervisory level. In these lower levels, the number of people led and the scope of operations are relatively small, but effective leadership is required in getting tasks accomplished.

Competent supervisors are indispensable. They are responsible for:

1. The conduct of others in the achievement of a particular task.

2. The maintenance of quality standards—work performance according to specifications.

3. The protection and care of materials.

4. Services to be rendered to those under their control.

5. Organization structures within their department.

6. Interpreting management to their men and vice versa. ◻

Highlights of the Second Institute

Th president confers with Wisconsin group: l. to r. Priscilla Rice, Eva Buckingham and Ruth Tempero.

l. to r. President-elect Julia Findlay, Buffalo, N.Y. and Alvira Rayfield, Chicago were busily taking notes.

l. to r. Ray Brown, Director of University of Chicago Clinics was the luncheon speaker and Eva Buckingham.

l. to r. E. Algminewicz and Eva Buckingham enjoy a short coffee break between sessions.

Arno Michlowitz, member of the board of directors, helped register the students.

Mable Hartley of Erie, Pa. was most pleased to receive a certificate.

Esther Abbott, our national Secretary, was a welcome addition to the institute.

Mary Helen Anderson graciously acted as institute coordinator.

Georgetta Baker of Phoenix, Arizona.

Shirley Wildblood from Vancouver, B.C. is pleased with the institute.

■ Our second institute is past history now but still the memory of a great deal of hard work and some pleasure cannot help but be reflected.

The institute started off with a bang when Doctor Letourneau made us give some thought to the future of central service. Many of us went away with an idea or two to confront our directors of nursing or the administrator. *Trends in Central Service* was most popular and this was borne out in evaluation questionnaire because it received the top billing when tabulations were finally complete. Following this Edna Prickett of American Sterilizer discussed *Isolation Techniques.* T. J. Carski, President of Baltimore Biological Labs and Dr. John H. Brewer, Director of Biological Research, Hynson Westcott, Dunning Company also of Baltimore discussed *Testing for Sterility and Lack of Toxicity in Disposable Medical Supplies.* The afternoon was equally as interesting with Mr. David L. G. Jacobs of Presbyterian-St. Luke's discussing *Training of Workers.* Mr. Jacobs is most popular with the group and

Everyone at the registration desk worked very hard. (l. to r.) Wilma Leppert, E. P. Johnson, Betty Hanna.

We were happy to welcome two travelers from afar. (l. to r.) Mary Murphy and Helma Mahoney both from San Francisco.

this is the second time we have had an opportunity to listen to him. Mr. Daniel E. Roop, Engineering Consultant gave us some pointers on *Preventive Maintenance,* and Mrs. D. Ann Sparmacher completed the afternoon by discussing *Communications.*

This year we tried something just a little different. We held a workshop the whole morning of December 1. It was most successful indeed and everyone enjoyed having the opportunity to "let their hair down." In the afternoon we discussed hospital relationships—Mr. Clyde Reynolds, Administrator of Provident Hospital, *Relationship of C.S. to Purchasing;* Dr. Quinn of the Veterans Administration, *Place of C.S. In the Organization Chart* and Eleanor Lambertson, *Relationship of C. S. to Nursing.*

On December 2 first thing in the morning was the report of the various workshops. It was obvious from the reports that everyone had worked very hard. They were both stimulating and thought-provoking. The audience participated most actively in the discussions. Fannie Nosziger, Operating Room Supervisor, University of Illinois Research, Chicago and Mrs. Iram Rupp, Obstetrical Supervisor of Chicago Wesley jointly discussed *Relation of C.S. to Operating Room and Obstetrics.*

We were most honored indeed to have a distinguished luncheon speaker. Mrs. Buckingham pulled some strings and behold Mr. Ray Brown, Director of the University of Chicago Clinics discussed *Factors Influencing Hospital Costs.* (Mr. Brown is Eva Buckingham's boss).

After the luncheon all the students at the institute were wisked away by buses to tour three hospitals—University of Illinois, County Hospital and Presbyterian-St. Luke's. All in all we learned a great deal, made some new friends and now we are looking forward to the next institute in Kansas City in November.

Note: We did not delve deeply into the presentations as it is our hope to print some of the papers presented at the institute in our forthcoming newsletters. We plan to report the workshop next month. ▣

Daniel Roop, Engineering Consultant, spoke on Preventive Maintenance.

Everybody worked hard and took numerous notes during the sessions.

I would like to know . . .

Sterile Soap

Do you feel it is necessary to sterilize soap for use in the obstetrical department?

I do not believe it necessary to sterilize soap for use in the obstetrical department.

Open vs Closed Shelving

Would you recommend open shelving or cupboards with doors be used in our c. s. department?

The decision concerning open shelving or cupboards with doors would depend upon your ability to ascertain the number of prepared items you intend utilizing. If these supplies are already in individual packages or boxes, cupboards with doors may prove more of a hindrance in expediting your work routine. However, consideration must be given to the fact that open shelving does tend to collect dust more rapidly and takes greater effort to keep clean.

Cleaning Levine Tubes, Rectal Tubes and Rectal Gloves

How do you clean and sterilize Levine tubes, rectal tubes, rectal gloves, between patients' use?

A. Levine and rectal tubes are syringed with a bulb syringe and detergent. They are then placed on spigets and flused. When clean, rectal tubes are packaged in a rectal tube Wrap. Size is put on each one. They are sterilized for 15 minutes.

B. Levine tubes are sterilized, hung up and covered until used. These are not packaged.

C. Rectal gloves are washed, powdered and the cuff folded over. All gloves for the right hand. These are placed in boxes as to size and go out surgically clean.

Disposable Gloves

Do you use disposable gloves?

Yes we do, but we can re-use this particular brand two or three times. Cost-wise, these are much more economical.

Rotating Assignments

Do you train aides in your department to rotate on all assignments?

Yes. This gives job satisfaction and variety each day and is more satisfactory to the worker. By being able to do this, they can do any job when there is absenteeism.

A Visit with . . .

Marie Edison

Central Material
Ireland Army Hospital
Ft. Knox, Kentucky

I reported here at this station in May of this year, having returned from a beautiful two year tour in Hawaii. I was assigned to the Central Material here in June, after seven weeks as Night Supervisor. This is a 500-bed hospital, which can be expanded to a 1000-bed hospital. This is a large post, and the Central Material here services five outlying dispensaries, the Reception Center Dispensary, Camp Breckinridge, Snow Mountain and the Civilian Dispensary.

We are located on the second floor adjacent to the operating room and the recovery ward. We have a large clean up area and sterile supply area. For an area of work space, we do not have enough space, as we do all the supplies in that room. The lady who does the OB supplies also does her work there and all our needles are cleaned in that room too. Since our glove room is too small, we have to do gloves in the work room. Our autoclave rooms are nice, and we have the large autoclaves. We have a syringe room and this plus the needles is our biggest problem.

We have two syringe washers and two needle cleaners, and we are in the process of getting a new Wright. As an average, in one week we gave out the following syringes and needles (23 ga.) to the dispensary; on Monday 2900, on Tuesday 2200, on Wednesday 3225, on Thursday 1450, on Friday 2400 and on Saturday 200. This is a total of 12,375 syringes and 23 gauge needles given out in a six-day period, and this goes on week after week. The Reception Center Dispensary will order anywhere from 1000 to 2500 a day. We put up all the syringes in trays of 200 - 100 - and 50 in a tray and the same number of needles in a pad laid right on top of the syringes.

We have convalescent patients from the wards come to the department and we let them clean the needles. We check them for burrs and pack them in gauze pads of 100 to a pad. This is a tremendous amount of work for a department. These dispensaries not only use syringes and needles, but also all sorts of sterile supplies which we put up for them.

Central Material does all the work for the OB department, but only the linen packs for the OR section.

I find that it is a constant race against time every day. Our department is authorized 10 enlisted men and seven civilian workes. We are open 24 hours a day. At the present we are short three enlisted men and two civilians. We work hard but we get a lot of satisfaction out of doing a good job.

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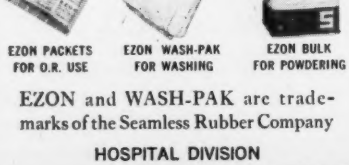

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CENTRAL SERVICE

by Mary Helen Anderson, R.N., M.S.H.A.

Personnel Orientation

The Nurse Aide in C.S.

■ HOSPITAL ADMINISTRATORS are constantly on the alert for "empire building" within the walls of the institutions of healing committed to their keeping. This is certainly as it should be, and we would be careful to make it clear that in pointing out the following concepts, there is no attempt whatever to build the Central Service department into an area of out-of-proportion importance in the hospital picture. Rather, it is the thinking of Central Service supervisors that a re-evaluation of the job descriptions pertaining to the personnel of C.S. is most timely. Since definite steps are being taken to define the duties, qualifications and skills needed by the ones to whom are given the administrative reins of the department, there would seem to be a logical progression to the consideration of the other large group of Central Service workers—the nurse's aide.

As a matter of interest, a job specification of a nurse aide was "lifted" from a nursing service manual in a large hospital in the middle west. In this hospital, a nurse aide is defined as a person who has been taught through an in-service training program to perform certain nursing procedures and to assist in other nursing functions. The qualifications include completion of grammar school with at least two years of high school. Average intelligence and good manners are requisites. Age range from 16 to 50 years.

Some twenty functions were listed, from the admission and discharge of patients, through morning and evening care, serving and collecting meal trays, giving and removing bedpans, taking temperatures, making beds, assisting patients into wheel chairs, to cleaning up the utility room. The very last item on the list was "return supplies to Central Sterile Supply."

In many hospitals new employees who are candidates for nurse aide positions are required to take a course of instruction covering most of the procedures mentioned above. At the end of that time an assignment is made to the nursing department, or to Central Service if an opening exists. From that point on the new employee is turned over to the C.S. supervisor to learn the departmental procedures. A suggested program for nurse aides begins with the proposition that it would be desirable to re-name the non-nurse members of the Central Service team. Because of the increasing use of expensive and complicated machinery in the Central Service Department, it is unthinkable that the person assigned to C.S. would be the one who "doesn't make the grade" as a nurse's aide. It seems imperative that because of the responsibility often given to the aide, that high school graduation be a requirement for the position. Therefore, it would follow that the designation "technician" might be in order for this person. Formal education cannot guarantee freedom from errors in judgment, but the ability to be taught the reason behind the procedures is most important.

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A 'Sexauer' Technician will make available our NEW Catalog, Edition "J", listing our entire line of over 3,000 TRIPLE-WEAR plumbing repair parts and tools. He will survey your fixtures, determine the repair parts needed and establish an efficient stock arrangement and control to prevent costly overstocking or shortages. You get this service without obligation. *Act now!*

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WORLD'S LEADING SPECIALISTS IN PLUMBING AND HEATING REPAIR PARTS

After a period of orientation to the general policies of the hospital (about one day), the elements of sterile technique should be outlined before a worker is turned loose in the department. To adopt the "buddy" system, where the new employee is assigned to one who has been in the department for some time, is not suggested as the best approach in the Central Service department. There are far too many short cuts that an old-time employee can consciously or unconsciously impart to the learner. The initial training of the Central Service worker should be undertaken by the supervisor, or a head nurse. This would mean that the new worker should not be assigned to the "clean-up room" on her first day. Points to be covered in her introduction to the department should include:

1. The system of communication between Central Service and the other departments of the hospital;
2. The physical lay-out of the Central Service Department;
3. Principles of sterilization—use the films and slides provided by the manufacturers of sterilizers;
4. Methods of decontamination of returned articles;
5. Preparation of sterilization;
6. Operation of the autoclave;
7. Storage of sterile items;
8. Charge system; controls used;
9. Tray by tray study of the items dispensed by Central Service—with a complete explanation of why and how the items are used. A planned observation of a spinal puncture will teach more about the tray set-up than all the pictures and diagrams in a C.S. manual. If the aide is adjudged intelligent enough to assemble the tray, she should also be capable of understanding the procedure as it applies to the patient.

There should be an opportunity for advancement within the Central Service department. Too often faithful aides have worked in the same area, doing the same things year in and year out with no prospect for change in status. There is no reason why the tasks in Central Service need all be performed by everyone in the department. While there is merit in the approach that "every member of the department can do every procedure," it is not always practical to continue that arrangement as the department grows. The parallel is seen in the diet kitchen. Surely every dietitian knows well the elements of good dishwashing, or of salad preparation, but not every member of the

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WRITE FOR CATALOG H-1

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Colorado Springs, Colorado

dietary department does every task required for meal service.

If the "nurse's aide" concept were removed from the Central Service worker, and the "technician" or "technical aide" substituted (much as has been done in the Operating Room) there would be opportunity for better selection, and surely much better performance within the department. Whether the department be a function of Nursing Service, or whether it be a specialty department under administration, the same idea applies. In the event of the department *not* under nursing service (as seems to be the trend), there would be more and more reason to develop the workers in another channel entirely than that of nurse's aides.

Another reason for dropping the nurse's aide as a job title for a C.S. worker is the large number of male workers who make a major contribution to the success of the department. Again the title of "orderly" only half-fits the duties within C.S. The designation "technician" would provide the answer for this problem.

The final advantage in the change from the nurse aide to the technician is that the ceiling for opportunity may be raised—with the Technician I, II, and even III, as the scope of responsibility is broadened. Of course the salary should be appropriate—a level between the aide and the practical nurse—or possible at a par with the practical nurse if there is sufficient training to warrant this wage scale.

As Central Service takes on new and more important roles in the hospital program, the personnel of the department must keep pace with the continuous demand for upgrading of performance. To measure up in production, we must be willing to offer dignity of position, opportunity for advancement, and systematic training on the job. ■

■ DATES of employment are most common area of falsification on application blanks. Other areas to watch are education, salary, age, and reasons for leaving. Such information on application blanks is reference-checked by 60 percent of companies responding to this Industrial Relations News survey. ■
— *Newsletter, Industrial Psychology, Inc.*

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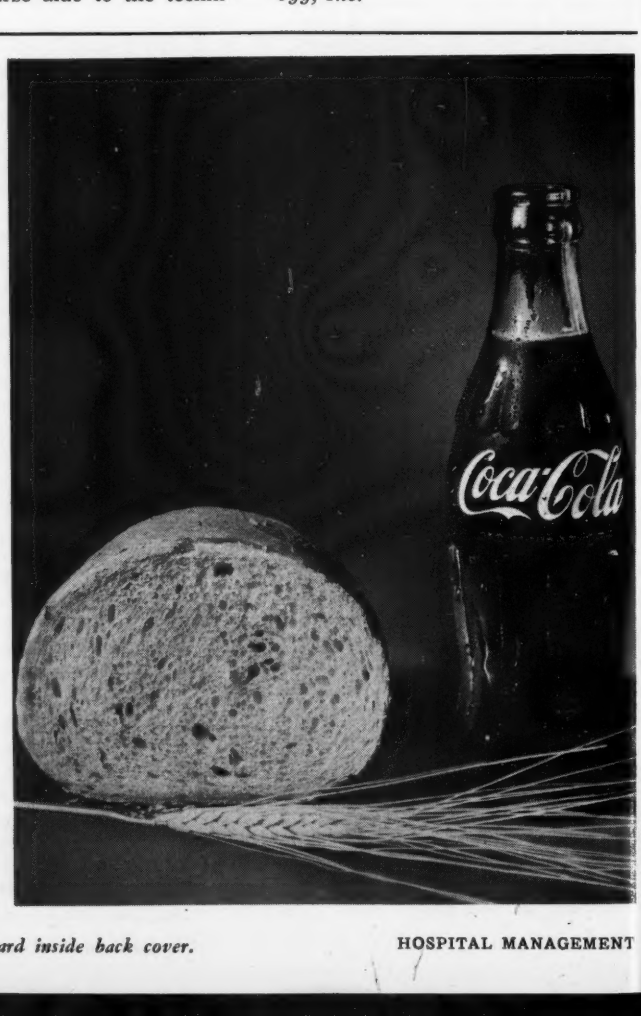

To Simplify Payroll Preparation —

Pay By The Day!

by John Hurley

Assistant Administrator
St. Catherine's Hospital
Omaha, Nebraska

■ WHETHER A HOSPITAL prepares its payroll manually or by machine, it is a time consuming task twice each month and anything that can be done to lighten the load should be undertaken.

Most hospital employees are paid on the basis of a monthly rate. Less used, except in the case of part-time personnel, is the hourly rate which offers many advantages. A formula which is little used but which has greater advantages is payment based on a *daily* rate.

If the hospital has a regular work week of five days, 104 days is deducted from 365. The remaining days (261) are then divided into the employee's annual wage to arrive at his daily rate. The same formula could apply if the hospital has a work-week of five and a half or six days.

With the exception of certain supervisory personnel whose pay is based on a monthly rate, all employees here are paid on the basis of this daily formula.

This means that absent days, whether due to sickness, vacation or for any other reason are not paid. Where an employee must work on one of the six national holidays, an additional day's pay is included in his check for that month.

Separate annual checks are issued for vacation and sick leave (our policy provides that personnel will be paid for sick leave days). Those employees who take sick leave within the year are docked at the time; but receive a check for eight days at year's end. This policy has helped reduce absenteeism because of real or alleged illness; likewise employees who have a good record of attendance are not penalized.

In this day, when approximately 65 percent of the hospital dollar goes for personnel, every work simplification method should be utilized which can help offset overhead costs. By using this method, one department can effect a saving in man hours and can simplify payroll preparation. ■

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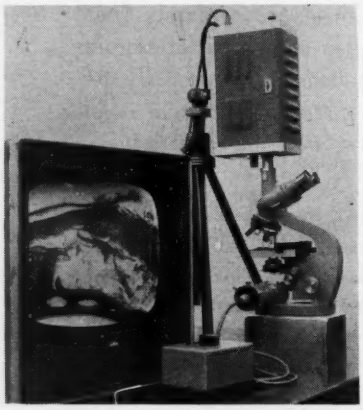
201 — Ultra Violet Sanitizer for Telephones

■ A BUILT-IN sanitizing system which kills bacteria, molds and virus within seconds after the mouthpiece is returned to its rest position, provides germ-free protection to all telephone users. It uses the Westinghouse "Sterilamp" tube developed to destroy bacteria and other micro-organisms deposited in the air or on exposed surfaces. Each time mouthpiece is replaced to its normal position, the tube is activated releasing a controlled amount of ultra-violet rays, destroying any organisms and odors which have been deposited by previous users. Literature available which includes scientific test data. (Sterile Telephone Corp.)

202 — High Resolution TV-Microscope System



■ A COMPLETE system mounted on a microscope as a basic teaching aid in school science courses, medical schools, and hospitals. The new system enables the instructor and students to see an enlarged, high definition image of the material from the microscope slide. The complete, compact unit plug into conventional 115-volt electric outlets, and the closed television system with three-lens turret added, is available to the institution for other closed-circuit TV functions. Price of complete package installed by authorized distributors is approximately $2200.00 Additional information on request. (Allen B. DuMont Laboratories)

203 — New Sound in Telephone Rings

■ A MODERN telephone ringing signal, has been developed for use with new compact telephones or as a replacement for existing ringers. The instrument is activated by an incoming call and emits a single bell tone at the beginning of the ringing cycle and a pleasing chime at the end — repeated at 3 second intervals as long as the call is not answered. The instrument is ideally suited for installation in executive offices, professional offices, quiet hospital areas and libraries. (Wheelock Signals)

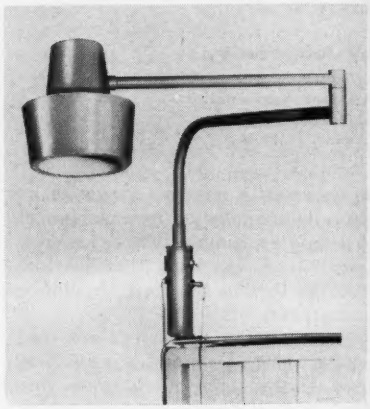
204 — Aerosol Disinfectant

■ THIS NEW AEROSOL is unique in that it kills all types of disease-producing bacteria whereas most aerosols in the past have been selective in their action and destroy only certain types of germs. This non-selective germ killer in aerosol form is simple to use — just spray it on the surface to be disinfected and wipe off the excess with a clean cloth. The formula has been registered with the U.S. Department of Agriculture. (James Varley & Sons)

205 — Vegetable Shortening

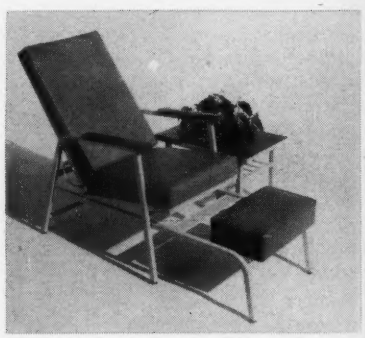
■ DESIGNED especially to impart excellent flavor and attractive appearance to grilled or pan fried foods. Reduces sticking and spattering. The shortening is a patented product made from domestic and imported vegetable oils by a patented process. May also be used for basting. Is not intended for deep frying. Requires no refrigeration. Packed in five gallon tins with 7-inch diameter friction lids to allow easy removal of contents. (Durkee Famous Foods)

206 — Hospital Bed Lamp



■ DESIGNED to be a complete, functional lighting unit. Provides floor lamp features, yet conserves valuable space, since it mounts in overbed frame sockets. Its 3½ foot horizontal reach makes it ideal for examining patients and applying dressings. Rugged coil springs inside heavy-duty ajusco swivels provide constant tension and prevent drifting. Approved by Underwriters' Laboratories. (Adjustable Fixture Co.)

207 — Adjustable Back Easy Chair with Ottoman



■ The chair, affords the patient with three positions — upright for sitting, reclining, and sleeping. Features a short seat cushion to make it easier to get in and out of. The upholstered pull-out ottoman disappears under chair when not in use, thus saving space. Chairs are built with the essential wallsaving feature, rubber-cushioned glides for easy movement, and feature exclusive life-long welded metal frame construction. Easy-to-clean elastic

Please turn to page 97

NATIONAL ASSOCIATION OF HOSPITAL PURCHASING AGENTS

Mrs. Orpha Daly Mohr
Secretary-treasurer
National Association of Hospital Purchasing Agents
Chicago Wesley Memorial Hospital
250 East Superior Street
Chicago 11, Illinois

A Salesman's Viewpoint

of Hospital Purchasing

by B. E. Dartnell

Division Sales Manager
The Stevens Companies
Winnepeg 1, Manitoba

Part I

While I address you as a Salesman, it so happens that in my particular firm I discharge a dual responsibility in certain specific areas. In these areas, I frequently assume the role of purchasing agent. I cite this fact because I must admit to a degree of bias in favor of purchasing procedures, compared to sales procedures.

Whilst carrying out my buying, I meet with a good many of exactly the same problems that you do. In short I have a foot in both camps. Nevertheless, I shall be as objective as I possibly can in presenting "A Salesman's Viewpoint of Hospital Purchasing."

During my fairly long career in the hospital supply business I have witnessed as you have, the gradual evolution of the purchasing function in hospitals from a rather haphazard discharge of a highly important and vital procedure (undertaken in many cases by nurses and medical staff, reluctantly grudging the time from other duties) to recognition of qualified key hospital personnel charged solely with purchasing as being absolutely essential to *both* the professional and economic aspects of the modern hospital.

I specifically mention the professional side of your responsibilities and mine because in no other field is the purchasing agent called upon to continually consider and exercise his judgment on matters that deal not only with the mechanical aspects of the products purchased, but also their relation to highly specialized techniques governing these products.

As we all know these techniques are changing constantly, some do attain a measure of permanency, but on balance changes are constantly disturbing the even tenor of our ways.

Here there is another factor that I should mention, in fact should stress. Techniques not only vary from province to province, from city to city, but very definitely from hospital to hospital. It follows then, and it is so, that not only are you called upon to have a general knowledge in the hospital field, but in particular you are the good right arm of your own hospital, placing in your hospital personnel's hands the precise and exact tools that enable them to follow the intricate procedures set up by your own institution.

Perhaps you will permit me a small digression here. Following the bias I mentioned previously, it rather seems to me that for too long a period of time in the institutional field at least, the real importance of the buying function has been submerged.

In the general conduct of the merchandising field, the contrary has long been the case. I could cite instance after instance where top business management exercises this important function. They travel to and buy in all the world markets and only after they have brought their judgment to bear on any given product does the sales organization take over. All important buying must proceed either sales or end use.

Happily within the institutional field a change is taking place. Even as recently as a short decade ago, I would not have had the privilege of addressing a specialized group such as this.

And now, if you will permit me to speak as a salesman, let me say first that it is the feeling of every

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Presented to the Hospital Purchasing Agents Association of Manitoba, at their annual meeting in Winnepeg, Manitoba on October 18, 1960.

competent salesman that he has a rightful place in the economic structure of the hospital, and that he fills a very definite need. Therefore, those purchasing agents who take full advantage of his services acquire a valuable aid.

Sometime ago I read a very interesting article in a hospital journal, and I should like at this time to quote one sentence which seems to make a lot of sense. "Creation of a more wholesome relationship between the hospital supplier and the hospital purchasing agent is necessary if both are to concentrate on their common goal—continuous improvement of the welfare of the hospital for the ultimate benefit of the patient. Since the overall welfare of the hospital patient is in the last analysis the primary objective of both the purchasing agent and the supplier, any factor which belittles the respective functions of either can jeopardize the progress of the hospital and may very possibly endanger patient's lives."

Since it would appear that the aims of both the purchasing agent and the salesman are identical, then when we meet to discuss purchasing and selling problems in the spirit of mutual respect, we are both contributing to the success of the hospital and the recovery and health of the patient.

Perhaps it would be best to first discuss some of the points which salesmen as a whole consider to be preventing the achievement of a completely happy relationhip between the purchasing agent and the supplier.

Bids

Let us first discuss the matter of bids. There is a divided opinion as to how much value buying by bids is to the purchasing agents. Many state owned institutions are compelled to purchase by bid and some of the purchasing agents who are familiar with this system are very much in favor of it, while on the other hand I have known a lot of them who would have been happier and would have done a better job if they had been permitted to exercise their ability as professional purchasing agents. In most cases, *price* is the only consideration or factor involved in bid buying.

It can be proved easily that the word "price" more often than not is actually an imaginary, intangible term; price is a title given to a quantity of goods. It tells nothing about durability, usefulness, safety,

The new furniture company sent over a stool specimen.

convenience, labor saving attributes, acceptability or overall quality. Therefore price can take on true significance only after the overall attributes of the respective products have been carefully appraised and measured.

It is not always possible to give exact specifications on every item. In some cases it can be done, but in others it is almost impossible. When a supplier does submit a bid, he usually has to calculate on the sale without recourse, and he knows he must supply the cheapest product that will meet the requirements of the bid. The quality, quantity, service or usefulness of the product are immaterial, and all the responsibility of the purchase rests with the purchaser. This to my mind is not the ideal condition for good purchasing.

When it becomes necessary, in the opinion of the purchasing agent, to buy by bid, then such bids should be treated fairly and not used to force reductions in price on the part of two or three suppliers, with the final result that one of the suppliers gets the opportunity to meet the price of the others after he has already bid. You will agree that this should not happen, but unfortunately it does. It is not good purchasing to play one supplier against the other, because better quality, service and delivery should count in the final analysis of the price.

Specifications on bids should be written in detail and accuracy is of extreme importance, in order to permit the supplier to bid properly and fairly. I have seen bids issued with a specification that would leave the requirements entirely up to the imagination of the supplier. For example, I recently received a request to bid on a tender for instruments which read like this:

6 dozen Haemostats
12 pair Operating Scissors
1 dozen Towel Clamps

On the first item we wonder what type, size and quality of haemostat is required and similarly, in the other two items, there were no details provided.

How, therefore, can the purchasing agent determine what is equal and what he will receive, if he places the order on the lowest price.

Naturally we realize that it is not possible for a purchasing agent to be an expert on every item he purchases, but certainly he can ask for help in preparing a specification. All he has to do is enlist the assistance of the party requisitioning the goods and call upon a salesman from a reputable supplier. These two people can and will make the specification realistic.

Brand names can be used in a specification, but should carry the additional words "or equal." However, in this instance, the purchasing agent should carefully consider the "or equal" product if he is going to accept this bid. Sometimes opinions differ on what is equal and this is where we expect the purchasing agent to demonstrate his true purchasing ability and not be completely influenced by the lowest bid.

If a supplier takes the time to fill out a bid, which sometimes is quite lengthy, then the purchasing agent should be prepared to let him know who the successful bidder was, and also explain the reason for his failure to get the order, i.e., price, not of equal quality, slow delivery, et cetera. This does not mean that the purchasing agent necessarily has to reveal the purchase price if he does not care to do so but that the order was placed on the basis of a lower bid.

Purchasing agents should not lose sight of the fact that bidding is an expensive way to do business. The detail work that must be done before the award is actually made consumes far more time frequently than a request for a quotation. I have many times been amazed at the reasoning which governs a purchasing agent to send out bids to five or six suppliers for $25.00 worth of merchandise.

Any saving on this bid would seldom be more than equal to the costs involved, so all the purchasing agent has succeeded in doing is to delay delivery to the department requisitioning. Wherever possible

the order should be awarded to a local supplier who can give the service you need promptly when you need it.

John Ruskin wrote something on the subject of bids which I feel will successfully close my discussion on bidding, and I quote:

"It's unwise to pay too much, but it's worse to pay too little. When you pay too much, you lose a little money—that is all. When you pay too little, you sometimes lose everything, because the thing you bought was incapable of doing the thing it was bought to do. The common law of business balance prohibits paying a little and getting a lot—it can't be done. If you deal with the lowest bidder, it is well to add something for the risk you run, and if you do that, you will have enough to pay for something better."

Salesmen

Next I should like to speak a bit about the treatment of salesmen by purchasing agents. Salesmen are human beings, subject to all the human frailties, and they are very sensitive to fair treatment. The salesman can be your best friend and trusted advisor. He calls regularly and is ready to help you in any way he can whenever you request him to do so. He supplies you with the latest product information, prices, and delivery.

Purchasing agents who see salesmen by appointment only between certain hours and on certain days work a real hardship on the out of town traveller. On the other hand, it suits the city salesman better to have a definite appointment on a certain day at a certain hour—so, may we ask that you be a little flexible in your allotment of time and consider the individual salesmen rather than having a hard and fast rule on "calling." If you cannot arrange to see a particular salesman, please let him know as soon as possible. You see, waiting around in the hope of an interview which does not materialize, costs both the salesman and his company money, which must be included in the cost of the end product.

Salesmen will readily acknowledge that most purchasing agents are better informed today than ever before. They realize that if they are to retain the respect of the purchasing agent, and to receive their share of his business, they too have to be better informed than ever. Some of the salesmen complain that when they walk into the purchasing agent's office the first thing they hear is "We do not need anything today." He is not given a chance to show new items or tell of any specials that his company may be ready to offer at that time.

It is to your own advantage to give the salesman a hearing. He is entitled to an audience with you; *you* owe it to your hospital to take advantage of all of the information he can give you; and the well-informed and well-qualified salesman can give you plenty. Salesmen like to sell their products on performance and quality. At this point, let us go further and discuss the problem created by the purchasing agent who puts an "iron curtain" around all departments and will not allow any individual to show department heads new things. He himself is either not trained to evaluate these new items or he doesn't have the time to do so. Yet his hospital loses the opportunity to learn of new developments. Certainly this attitude defeats our common goal "The recovery and health of the patient." Many of the salesmen who call upon you work on a commission basis. If they do not reach a sales quota sufficient to cover their drawing accounts, they do not receive the commission. If they have to spend a great deal of time sitting around in a purchasing office, they cannot make enough calls in a day to reach their sales quota. By and large, you will find them a very patient lot. They are perfectly willing to tell you about anything that is new and interesting, so don't neglect this valuable source of information; ask them to call back at a more convenient time, if you are busy at the moment.

I said, the boss will see you now.

The reputable supplier feels that it is his responsibility that the hospital receive a quality and quantity of product that will meet the requirements of the individual hospital. He also feels that he should be completely informed about the need and use of the product by direct discussion with the ultimate users, and then subsequent discussion with the purchasing agent, so that he may intelligently recommend and assume his responsibility. Bear in mind that a supplier, if given the confidence of the purchasing agent, will not only render good service but will give full information and wholehearted cooperation. He is anxious to keep his relations with his customer for many years to come.

It is grossly unfair to quote or lead a salesman to believe that you have a better price than he has quoted you. Purchasing is a science and the scientific way to do the job is to accept the salesman's quotation, and let it go at that. If his price is too high, he has lost the business. Quibbling over prices in an effort to beat down the quotation you have received is not scientific purchasing, and it has no place in legitimate administration. On the other hand, I feel selling is similar to a profession and no doubt you have met many professional salesmen. It's their job to know the market; to know your needs, to know what he can supply that will adequately and economically meet your requirements, when he can make delivery, and anything else you may want to know about the product you wish to buy. If he can't do all of these, he's not a professional salesman and he deserves to lose your business.

Salesmen Don't Like Sympathy Orders!

As much as we appreciate your business, sympathy orders are sometimes a nuisance and they are both costly to the hospital and the supplier. Let me explain just what I mean by sympathy orders. When a salesman from a supplier with whom you are not in the habit of doing business calls upon you regularly, sometimes the purchasing agent will feel sorry for him and give him a token order just to keep him from going away empty handed. These small orders may make the purchasing agent's conscience feel better, but they have no place in scientific purchasing and salesmen are the first to admit this point. So we say, no sympathy orders please!

The "Sixty-Four Dollar Question" Column

Permission to reprint this Column each month for the National Association of Hospital Purchasing Agents was granted by Mr. Frank M. Rhatigan, secretary of the American Surgical Trade Association.

QUESTION: ***Who makes the Richfol abdominal belt?***
ANSWER: United States Truss Co., 238 E. 4th St., Cincinnati 2, Ohio.

QUESTION: ***What is source of supply on Rock Mulligan polyethylene hood umbrella splints used in OB and GYN?***
ANSWER: The Holter Company, 3rd and Mill Streets, Bridgeport, Pa. has worked closely with Drs. Rock, Mulligan, and Garcia and can supply these hoods made of Silastic (Dow Corning Silicone Rubber.)

QUESTION: ***Who makes a guillotine type instrument used in removing gangrenous toes and fingers?***
ANSWER: Sanders Pressure Necrosis Amputator—a stainless steel instrument for amputating toes of a poor surgical risk. Painless and bloodless operation. At one time sold by John Bunn Corporation, 163 Ashland Ave., Buffalo, N. Y.

QUESTION: ***Is a disposable wet floor mop made, and by whom?***
ANSWER: Busse Hospital Products Co., 64 E. 8th St., New York 3, N. Y.

QUESTION: ***Is there someone who makes up complete Jackson trachea tubes from odd parts in stock?***
ANSWER: Dittmar and Penn Corporation, 5155 Belfield Ave., Philadelphia 44, Pa.

QUESTION: ***Who makes the Bowman suction pump for vascular surgery?***
ANSWER: Process & Instrument Co., 15 Stone Ave., Brooklyn, N.Y.

QUESTION: ***Who is the manufacturer of a timer with many punch-in buttons so it can be set to ring at intervals throughout the day? It is recommended for laboratory use.***
ANSWER: Andrew Technical Supply Company, 1743 W. Rosehill Drive, Chicago 26, Ill.

QUESTION: ***Where can we obtain the Lancaster umbilical cord bander with 100 bands?***
ANSWER: Moose Brothers, Port Lavaca, Texas, are the manufacturers.

QUESTION: ***Can you furnish us with the name of the manufacturer of a mechanical freezing device known as Histo Freeze?***
ANSWER: This item is available only from American Hospital Supply Corp., Scientific Products Div., 2020 Ridge Ave., Evanston, Ill.

QUESTION: ***Mail addressed to Tyrell Hygiene Institute, 3 Park Row, New York City, N. Y., is returned. Do you know present address?***
ANSWER: The J B L Cascade enema bag, formerly available from the Tyrell Hygienic Institute is now available from Tyrex Drug & Chemical Corp., 42 Newark St., Hoboken, N. J.

QUESTION: ***Do you know who makes an Opthalmo synamometer?***
ANSWER: Ophthalmodynamometer—available from Codman & Shurtleff, Inc., 104 Brookline Ave., Boston 15, Mass. and Matalene Surgical Instruments Co., 480 Lexington Ave., New York 17, N. Y.

QUESTION: ***What is the source of supply for a child size Davis ether mask?***
ANSWER: Dittmar and Penn Corp., 5155 Belfield Ave., Philadelphia 44, Pa., lists an adult size. Sierra Engineering Co., R. A. Hawks Division, 123 E. Montecito Ave., Sierra Madre, Calif., makes a child-size ether mask.

QUESTION: ***Advise us the name and address of manufacturer of dispenser for 1 oz. plastic medicine cups.***
ANSWER: Busse Hospital Products Co., 64 E. 8th St., New York, N.Y.

QUESTION: ***What is the present address of M.F.G. Enterprise, formerly 920 Township Lane, Elkins Park, Pa., who makes an electric deodorizer and refill cartridge for same?***
ANSWER: The Barnaby-Cheyney Electric Deodorizer and Refill Cartridge are available from Mine Safety Appliance Co., 201 N. Braddock Ave., Pittsburgh 8, Pa.

QUESTION: ***What is the source of supply for the Dymo-Mite labeler for embossing plastic or metal labels?***
ANSWER: Made by Dymo Corp., 2725 10th St., Berkeley,, Calif.

QUESTION: ***Advise name of manufacturer of Redi-Swabs, aseptic swabs for topical use.***
ANSWER: Redi Products Laboratory, Box 1298, Huntington, W. Va.
(*Note: We previously listed Graham-Field Surgical Company as the manufacturer of this product. Actually, G-F markets a similar product under the name Redi-Asepti-Swabs.*)

QUESTION: ***What is the correct address of Rasmussen Products, who make shut-off clamps S. S.?***
ANSWER: Olaf Rasmussen, Port Clinton, Ohio.

QUESTION: ***Do you know the present address of James J. Holland, formerly of Parkersburg, Pa., manufacturer of the Holland eye magnet?***
ANSWER: As far back as 1957 mail addressed as above was returned marked "out of business."

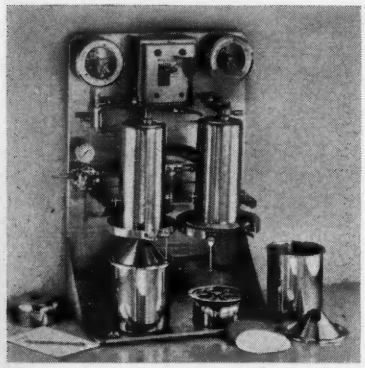
QUESTION: ***What is the address of Rack-Rite, who make dressing baskets?***
ANSWER: Rack-Rite Co., 4560 Justine Ave., St. Louis, Mo.

Product News

Continued from page 90

backed vinyl upholstery in modern patterns over foam latex cushioning provides a firm comfortable seat and back. Chairs have walnut or maple solid wood arms. Seat and back cushions are reversible. (The Hard Manufacturing Company)

208 — Speedfilter



■ THE NEW FILTER, with high pressure and variable filter design, reduces filtration of large volumes of light or heavy precipitates to minutes instead of days of laborious filtration routine. Two filter tanks, both 3.5 liters, may be run simultaneously or independently at predetermined pressures up to 80 psi offering impelling forces five times greater than vacuum techniques. Pressure is supplied from laboratory air supply line, bottled gas, or separate compressor. Equipped with rigid sintered stainless steel filter discs thus filling the gap between other types of filtering devices that process very small quantities or bulk. Simple three-step operation does the job. (Spincraft, Inc.)

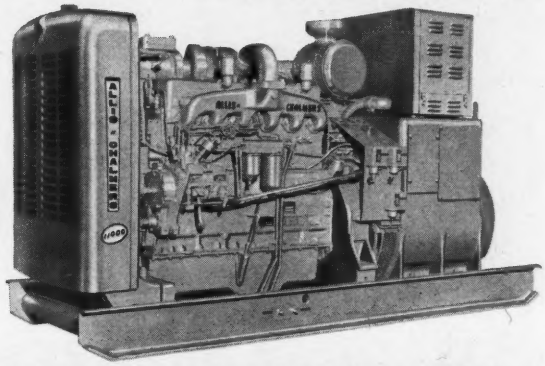
209 — Wall Washing Machine

■ THIS MACHINE, constructed of stainless steel and other noncorrosive metals has just been redesigned to provide faster wall washing. Two men can operate from one machine, giving twice the volume of work. Weighs 25 pounds and is easy to transport. A new detergent supplied with the machine requires only two operations; washing and buffing. No rinsing required. Three or four ounces of detergent makes one gallon of solution . . . enough to clean 1,000 sq. ft. Further information on request. (Von Schrader Mfg. Co.)

210 — Surgical Tape

■ A NEW MICROPOROUS surgical tape which provides almost complete relief from skin irritation, according to clinical records compiled on more than 1,000 patients. The tape has a backing and adhesive which feature countless tiny airways, permit-

Allis-Chalmers ANNOUNCES



11000

110-kw DIESEL ELECTRIC SET

WITH A NEW KIND OF WORK POWER

AND BRUSHLESS GENERATOR

It's *double* new! For the first time you can have the advantages of brushless generators in this size . . . PLUS diesel engine power featuring controlled turbulence combustion. This gives you a combination that is:

Easy To Install — Your advantages start the minute you install an Allis-Chalmers generating set, for the installation itself is simple. This self-contained, unit-type set is mounted on rigid skids. There is no need for special foundation . . . no danger of misalignment.

Quick To Start — It takes as little as four seconds to start and pick up the load. Allis-Chalmers' unique combustion system "kicks over" instantly on diesel fuel. Magnetic amplifier-type static voltage regulator allows generator to pick up heavy starting loads easily.

Uses Safe Diesel Fuel — Economically — Controlled turbulence assures *complete* combustion . . . full utilization of fuel. Tests show fuel savings of up to 27 percent over other diesel units in this size range.

Simple To Service and Maintain — Allis-Chalmers regulator has no moving parts or contacts to burn or wear. The generator has no slip rings, no brushes, no commutators to wear or spark. Further, all major components—engine, regulator, generator and switchgear—are engineered, coordinated, built and *backed* by a single manufacturer.

Let your Allis-Chalmers dealer give you complete facts and specs. For more information write Allis-Chalmers, Milwaukee 1, Wisconsin.

ALLIS-CHALMERS

POWER FOR A GROWING WORLD

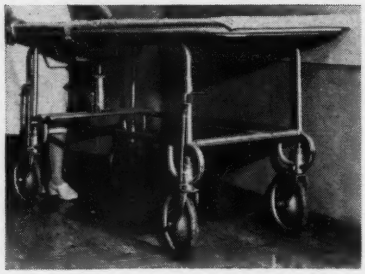
AC

BG-42

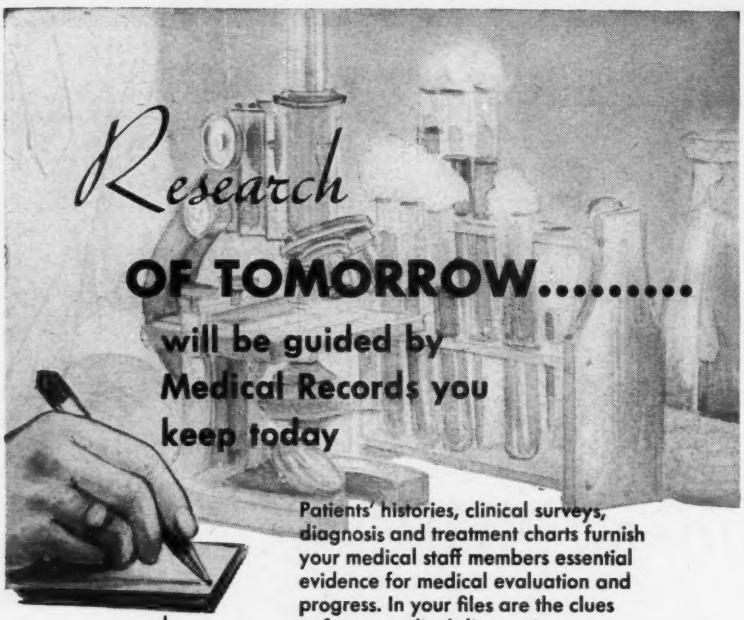
For more information, use yellow postcard inside back cover.

ting the skin beneath the tape to function normally. This unique "breathing" feature prevents occlusion of the skin. The tape, even after being on the skin for prolonged periods, can be removed painlessly. Tape does not cause itching, cannot sweat off, and has an improved cosmetic appearance. (Minnesota Mining and Mfg. Co.)

211 — Guerney Guards



■ THESE NEW GUARDS made of durable Formica laminated plastic effectively reduce maintenance costs in at least one hospital. A strip of Formica, one foot wide is applied directly to corridor walls, 31 inches above the floor line, just at the height of the damage causing beds and carts. In addition to withstanding the punishment of corridor traffic, the strips of Formica require minimum care to be kept antiseptically clean. (Formica Corporation)



Patients' histories, clinical surveys, diagnosis and treatment charts furnish your medical staff members essential evidence for medical evaluation and progress. In your files are the clues to future medical discoveries.

Realizing this, your selection of record forms becomes of utmost importance. Physicians' Record Company standardized forms fulfill the requirements of the Joint Commission on Accreditation and other professional agencies. They give complete information, yet retain simplicity and compactness.

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Reasonable prices, uniform quality, prompt and efficient service

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• BERWYN, ILLINOIS •

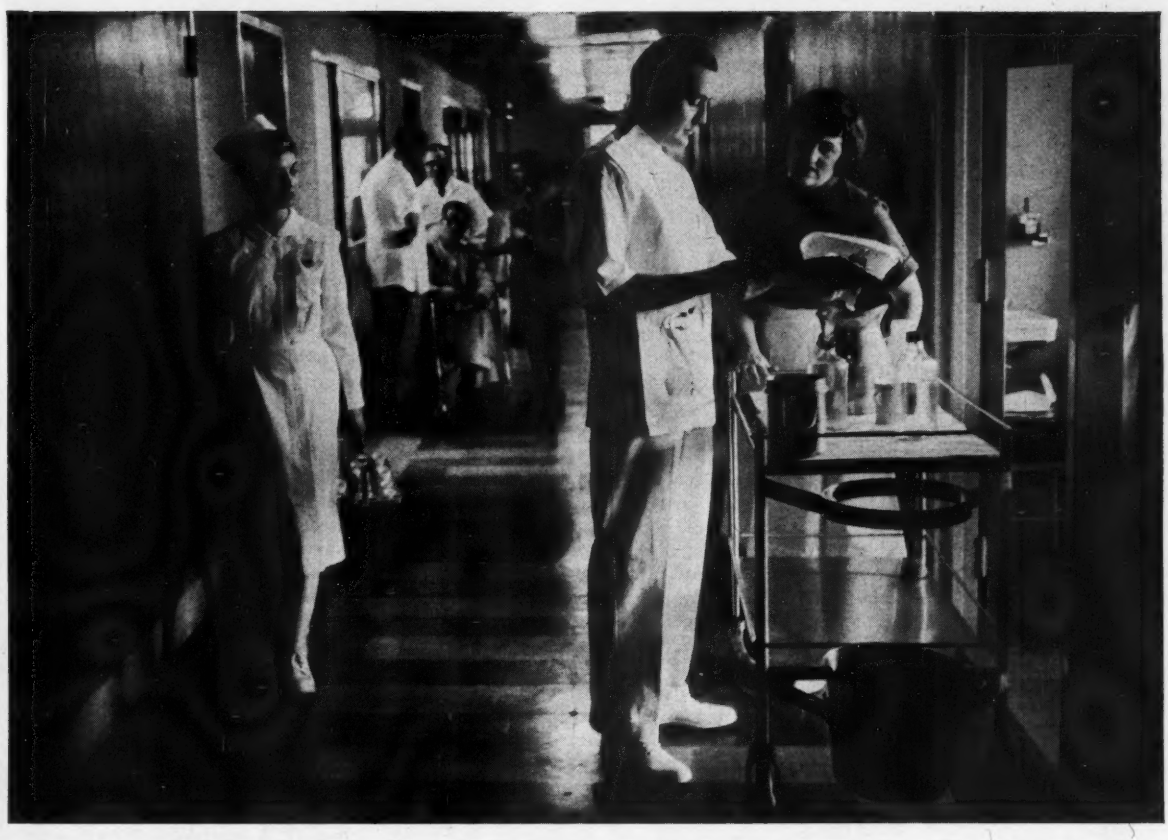
Publishers of Hospital and Medical Records Since 1907

212 — Pediatric Bath

■ A NEW PEDIATRIC bath, designed specifically for hospital use. This wall-hung china tub marks an important addition to the hospital pediatric department because it eliminates the adaptation of conventional fixtures for young children. The bath can be mounted at counter height so that nurses can handle bathing chores without bending strain. A shelf can be erected on the side of tub to provide a convenient drying area. The tub is 28″ x 22″, with a back height of 17½″ and a height of 11″ at the lowest point of the front rim. The 5″ wide shelf back provides a handy ledge for soap and other toilet or medical articles. (American Standard Corp.)

213 — Canned Meat Products

■ A DIVERSIFIED institutional line of canned meat products designed expressly for hospitals is now available. A total of 11 items are packed under the Morrell Pride Label, all inspected and passed by the U. S. Department of Agriculture. The line includes 6½ lb. tins of: Beef and gravy, pork and gravy, beef with barbecue sauce, pork with barbecue sauce, corned beef hash, chili con carne with beans, ham shanks and ham chunks. Two-lb. cans of boned chicken, and boned turkey and six and three-quarter lbs. tins of Ox Tongue. (John Morrell & Co.)



IN TOTAL HOSPITAL WAR AGAINST STAPH.

antibacterial detergent with 3% hexachlorophene

pHisoHex®

for all personnel with patient contacts

Thorough washing with the antiseptic detergent, pHisoHex, is a simple hygienic measure that can help reduce staphylococcal and other infections if adopted by **all hospital personnel attending patients.** Such a hospital procedure has "...proved effective in controlling the spread of infection...."[1] Routine washing with pHisoHex is suggested not only for surgeons, physicians and nurses, but also for nurses' aids, food handlers and members of the housekeeping and laundry staff. Home use by surgeons and nurses augments results still further.

"...the bactericidal effect of pHisoHex can be attributed to the efficient deposition of hexachlorophene as a semi-permanent film on the skin of frequent users."[2] Hexachlorophene is particularly effective against staphylococci.[3]

pHisoHex is a potent antibacterial, hypoallergenic detergent with "...a surface tension reducent 40% more powerful than soap."[2]

1. Benson, Margaret E.: Am. J. Nursing 57:1136, Sept., 1957. 2. Smylie, H. G.; Webster, C. U., and Bruce, M. L.: Brit. M. J. 2:606, Oct. 3, 1959. 3. Ayliffe, G. A. J.; Alder, V. G., and Gillespie, W. A.: Lancet 2:456, Sept. 26, 1959.

Winthrop LABORATORIES, New York 18, N. Y.

For more information, use yellow postcard inside back cover.

Fire Drills and inspection

■ THE FIRE HAZARD in hospitals is much greater than in schools, hotels, and other institutions because most of the population is not ambulatory. In contrast to the situation in schools, for example, hospitals cannot, for obvious reasons, practice fire drills with patients participating. Because of this condition, a much greater amount of time will be needed to evacuate these people in case of emergency. The rule rather than the exception in such an unfortunate circumstance is that a minimum of staff personnel (mostly female) must cope with the evacuation of many people who will require considerable physical help and more than usual psychological attention to prevent hysteria.

The need, then, for fire education and regularly scheduled fire drills for administrative, professional and service staffs cannot be overstated. It is not an outrageous or unreasonable suggestion that many hospital personnel, particularly those working in the service areas (which are where 52.1 percent of hospital fires start) are completely in the dark as to what their individual responsibilities are should a fire develop. Basic, verbal, step-by-step instructions should be given to each individual employee by his particular department head as to his duties in just such an emergency.

In addition, it should be the responsibility of the administrative staff at least once a week to make the rounds of the hospital to detect and remove any incipient fire conditions. Things to look for: old rubbish, discarded mattresses (not those stored in sprinklered rooms), piles of linen or rags, oily rags, open paint cans and cleaning chemicals, cluttered gas storage areas, dirty kitchen range filters, and the like.

That smoking should be well regulated in hospitals is too obvious a point to mention. To some people, smoking is such an ingrained habit that any attempt at restriction or restraint is met at times with astounding emotional reaction. With the increasing number of patient days and consequent rise in numbers of visitors, hospitals seem to be fighting a losing battle on any kind of restrictions. Obviously there is no easy solution to the smoking problem, but it is a rare thing indeed to read any cautions about smoking in visitors' bulletins and even rarer to see any signs other than in hazardous locations reminding personnel and patients about latent fire dangers with improperly discarded cigarets.

It is interesting to note that in the spring of last year, the Los Angeles Fire Department conducted countless fire experiments in an abandoned school building to determine what happens when a building catches fire and of what practical value are many of the safety devices offered to institutions. Sponsored by the Ford Foundation, a 264-page report on these experiments concluded that the only safety device that showed promise of all-round protection was the completely automatic sprinkler system with built-in heat triggered alarms.

It noted that fire retardant paint, vents, curtain boards, partial automatic sprinklers (and combinations of the four), and automatic heat and smoke detection devices failed to measure up to expectations and were not satisfactory. Many hospitals have objected to the installation of complete sprinkler systems (for economic reasons); recently, however, a few hospitals have amortized the cost of this system in only five years through a substantial reduction in fire insurance after installation.—*Hospital Bureau Inc.* ■

90% OF FLOOR MOPPING COST IS LABOR . . .
CAN YOU AFFORD NOT TO USE THE BEST TOOLS?
Geerpres
Write for new catalog!
GEERPRES WRINGER, INC.
P.O. BOX 658, MUSKEGON, MICHIGAN

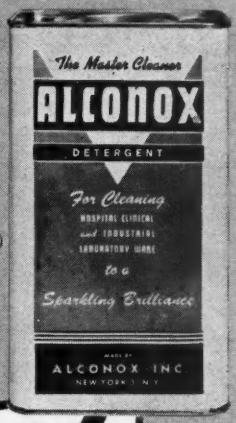
New Safety Code for Window Cleaning

■ American Standard Safety Code for Window Cleaners, A-39-1-1951, is available at $1 per copy from the American Standards Assoc., Dept. PR 168, 10 E. 40th St., New York 16.

The new code applies to all window cleaning operations performed wholly or partially on the outside of a public building more than one story high, or on which the sills of the windows are located more than six feet above grade or above adjoining flat roofs. The rules set down in the code apply to the cleaning of the inside face of any window where the window cleaner is working from a level ten feet or more above the floor.

Included in the code are specifications and test methods for anchors and belts, and a detailed method for fastening anchors. It also spells out how and when such apparatus as swinging and built-up scaffolds, boatswain's chairs and ladders shall be used. ■

THE WORLD'S FINEST DETERGENT



Proven the world's finest and most economical detergent for the exacting requirements of Hospital, Medical and Laboratory use.

MEETS HIGHEST U.S. GOVERNMENT SPECIFICATIONS

MORE WETTING POWER!

MORE SEQUESTERING POWER!

MORE EMULSIFYING EFFECT!

QUICKLY, COMPLETELY SOLUBLE AND RINSABLE!

More effective than any known detergent in powder form or any liquid detergent that costs four times as much!

ALCONOX
The Master Cleaner

Sold throughout the world!

ALCONOX announces with Pride its new Companion Line of

H&L HOSPITAL BRAND LABORATORY PRODUCTS

SUPERIOR SPRAY PRODUCTS for DOCTORS and HOSPITALS

COMPARE THESE PRICES for proof that nowhere in America can you duplicate such matchless low costs for products of such unquestionable quality in economy-size 12-oz. cans!

H & L Spray SKIN PROTECTOR
with Dow Corning Silicones

Formulated with the skin-soothing properties and protection of silicones and the bacteriostatic action of hexachlorophene to aid in the prevention of contact dermatitis, intertrego and miliaria among bed-ridden, incontinent patients and to prevent the subsequent formation of decubitus ulcers. Its use will minimize cross infection.

12-oz. Can, $1.65 ea. In case of 12 Cans, $1.45 ea.
Per Case, $17.40

H & L Spray FREEZE *with du Pont Freon®*

For quick, temporary, topical anasthesia of the skin by freezing for minor surgery.

12 oz. Can, $2.18 ea. In Case of 12 Cans, $1.86 ea.
Per Case, $22.32

H & L Spray ADHESIVE TAPE REMOVER

Removes adhesive tape painlessly, also any tape markings remaining.

12 oz. Can, $1.35 ea. In case of 12 Cans, $1.15 ea.
Per Case, $13.80

H & L Spray BANDAGE *with Neomycin*

Provides a new method for the quick and easy application of a sterile, transparent, flexible film, which adheres to the surface of the skin, providing an obstacle to bacteria.

12 oz. Can, $2.30 ea. In Case of 12 Cans, $2.00 ea.
Per Case, $24.00

H & L Spray U.S.P. TINCTURE of BENZOIN
In Aerosol

Improves adhesive properties of tape and minimizes patient's discomfort during long tape and cast applications. For the prevention of bed sores, we suggest H & L Skin Protector.

12 oz. Can, $2.00 ea. In Case of 12 Cans, $1.70 ea.
Per Case, $20.40

H & L Spray ROOM DEODORANT

The outstanding sick-room deodorant. Kills odors chemically. Contains no masking agent.

12 oz. Can, $1.35 ea. In Case of 12 Cans, $1.15 ea.
Per Case, $13.80

ASSORTED CASE 2 Cans of each of the above 6 items **$18.80**

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ORDER TODAY FROM YOUR SUPPLIER

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POSITIONS OPEN

REGISTERED MEDICAL RECORDS LIBRARIAN in large beautiful hospital in Fort Lauderdale, Florida. Opportunity for advancement in the "Land of Fun and Sun." Excellent pay, ideal working conditions and many benefits. For details contact:
District Personnel Director
North Broward Hospital District
1600 S. Andrews Avenue
Fort Lauderdale, Florida.

WANTED: Assistant Director Medical Record Department. Must be registered or eligible for registration. 481 bed general hospital. Good personnel policies, pleasant working conditions, opportunity to work with P.A.S. Salary commensurate with experience. Write Mr. James Dunlop, Administrator, BRIDGEPORT HOSPITAL, Bridgeport, Connecticut.

DIETITION needed for 93 bed JCHA approved general hospital located on South Atlantic coast. Prefer ADA member with hospital experience. Good personnel policies. Salary open. Send resume, including references, experience, date available, and salary desired in first letter. Apply Miss Ruth M. Puehler, Administrator, Georgetown County Memorial Hospital, Georgetown, South Carolina.

DIRECTOR OF NURSING SERVICE — Excellent opportunity for qualified person. General hospital, fully accredited, 132 beds. Affiliated with Alfred University School of Nursing. Salary open. Excellent personnel policies including group life and pension plan. Apply to Administrator, CORNING HOSPITAL, Corning, New York.

FOR SALE

BRONZE AND ALUMINUM PLAQUES. Name Plates and Donors Tablets. For lowest prices, write for free pamphlet. ARCHITECTURAL BRONZE & ALUMINUM Corp., 3638 W. Oakton St., Skokie, Ill.

FOR RESULTS THAT COUNT —

In a recent issue, surveys showed that one out of every 3 readers were definitely interested in the classified ads.

To fill a job, get a job, sell equipment, or to fill your needs, use the classified pages of HOSPITAL MANAGEMENT. 14,000 subscribers — over 56,000 readers!

Interstate Medical Personnel Bureau
333 Bulkley Building
Cleveland 15, O.
Miss Elsie Dey, Director

POSITIONS WANTED

PURCHASING AGENT: 15 years experience, 375 bed Ohio hospital. Available.

ASSISTANT ADMINISTRATOR: M.H.A. Degree, mid-western university. 3 years experience, 400 bed Ohio hospital as Personnel Director.

ADMINISTRATOR: M.H.A. Degree; F.A.C.H.A. 7 years experience, medium-size hospital, Michigan. Desires change.

R.N. ADMINISTRATOR: Courses in Hospital Administration, regarded as good business manager. 10 years experience, 70-125 bed hospitals.

MAINTENANCE DIRECTOR: Degree in Engineering. 12 years experience; also acted as consulting engineering for numerous hospitals.

EXECUTIVE HOUSEKEEPER: Courses in Institutional Housekeeping. 2 years Assistant Housekeeper; 7 years 375 bed mid-western hospital.

POSITIONS OPEN

ASSISTANT ADMINISTRATOR: 375 bed western hospital; college community. (b) 275 bed Ohio hospital. (c) 175 bed hospital Iowa.

ADMINISTRATOR: Large mid-western hospital; experience required. $15,000 up. (b) 115 bed eastern hospital. (c) 45 bed Ohio hospital. (d) R.N. 55 bed hospital, mid-west.

COMPTROLLER: 300 bed hospital, Pennsylvania. (b) Business Manager. 250 bed mid-western hospital.

PERSONNEL DIRECTOR: 165 bed Ohio hospital. (c) Administrative Assistant. Degree, Business Administration. 175 bed hospital, Ohio.

DIRECTORS OF NURSING. To $10,000.

EXECUTIVE HOUSEKEEPER: 300 bed hospital, South. (b) 145 bed hospital, Maryland. (c) 250 bed Michigan. hospital. (d) 300 bed hospital, west coast. (e) 200 bed Ohio hospital.

CHIEF ENGINEER: 250 bed hospital, central states. (b) Sisters' hospital, mid-west.

TECHNICIANS: Laboratory: X-ray. To $500.

MISCELLANEOUS

WANTED: Surplus Catagut in tubes. Write: W. F. Harlton, Jr., PO Box 412, Detroit 32, Michigan.

ADMINISTRATORS: (a) Medical; Dir med educ; newly created post; 300-bd fully accred genrl hsp under capable direction of FACHA; $22-$24,000; reqs able MD w/tchg program exper; lge city; (b) Asst med dir; very lge fully-apprvd gen tchg hsp; reqs min, 1 yr apprvd internshp, adm exper; $12,000 NY state. (c) Dir of Institutions; key position, lge county prog; reqs college man w/broad adm exper; to $22,000; MW. (d) 650-bds; 2 units; tchg prog; fully-accred; reqs min of 5 yrs exp in hsps 500-bds or over; SE. (e) 350-bd, fully-approved, gen; pref FACHA; near NYC. (f) Male or female w/5 yrs adm exper; new 130-bd JCAH vol gen hsp; min $10,000; MW. (g) 50-bd. Psych inst; $10,-$12,000; Calif (h) Asst; dir PH for hsp servs; very lge fully accred tchg facilities (4 units) $18-$20,000, more for outstand man; W. coast. (i) Asst dir; 700-bd fully-accred gen; $12-$14,000; MW (j) Asst; new post; 300-bd fully-accred gen; expandg on Mexican Gulf. (k) Asst; large JCAH gen vol hsp; to $8,000; resort area; Fla. (l) Asst adm w/qual for post of this type; 125-bd hsp w/active expansion program; substantial salary; Calif.

ADMINISTRATIVE POSTS: (m) adm officer; univ hsp, 650-bds; duties, dir clinic diagnostic labs; dept hd status; $8,000 SE. (n) Adm asst; 275-bd fully-accred gen hsp; excel set-up w/sal commensurate w/exp & educ; nr NYC. (o) Adm asst; Hsp Council; 40 members; sal open; about $7,200; MW. (p) Adm assistant; male or female; for evenings; 400-bd. fully accred gen hsp; will be excel trng for yng grad; $5,500-$6,000; Chgo area. (q) Fund raiser, exper; new 125-bd gen hsp; $7,500 up; MW. (r) Compt. w/degree in Acctg; for 350-bd fully-accred gen hsp; Fla. (s) Pers dir, w/BS in Pers or Inds Mangmnt; pref w/hsp exper; for excel cl & assoc'd 250-bd hsp; E. (t) Public Relations Dir; 700-bd gen; $12,000; MW. (u) Purcasng dir; to head purchasing, 26 allied hsps; reqs exper man pref w/hsp backrnd; E.

POSITIONS WANTED

ADMINISTRATOR: 40; outstandg man with excel references; past 5 yrs, dir, 200-bd gen; seeks adm larger hsp; Member ACHA any locality.

ADMINISTRATION OR ASSISTANTSHIP: (a) 31; BS (bus adm); MSHA; 2 yrs adm asst; 4 yrs asst adm, 300-bd gen hsp; no oppt further advancement; qual as adm smaller hsp or asst lge hsp; excel references; any lcc; immed avail. (b) BS, acctg, MHA; 1 yr asst adm 300-bd hsp; 3 yrs adm 100-bd hsp; seeks adm 100-bds up, or asst adm lge hsp; FAHA; early 40's. (c) Asst; 26; BA, Harvard MHA, Mich; Fellow in Adm, June 60-61 seeks asst adm gen hsp 150-350 bds; any location.

ANESTHESIOLOGIST: 46; 6 yrs successfull private practice before specializing; 6 yrs, dir, Anes, 250-bd hsp; seeks lge community hsp or teaching hsp w/academic rank; Diplomate. immed available.

PATHOLOGIST: 32; Cert, CP & AP; 5 yr path res; 2 yrs assoc path 275-bd fully accred hsp w/no oppt further advance; consider hsp appntmnt as assoc or dir.

RADIOLOGIST: Dipl, diag & ther; 5 yrs assoc rad, 500-bd hsp; seeks Chiefship small or med size hsp; middle 30's.

reverse hypovolemic shock quickly, economically

without the dangers of blood transfusion

An estimated 3,000 patients die each year as the result of blood transfusion reactions.[1] When hypovolemic shock is treated with ALBUMISOL®, most of the risks inherent in blood transfusion are bypassed. With ALBUMISOL, there is— **■ no danger of hepatitis ■ no waiting or expense for typing, cross-matching, or grouping.**

Most importantly, ALBUMISOL is the protein responsible for 80 per cent of the colloid osmotic pressure of plasma. It therefore fills the most urgent need in hypovolemic shock—restoration of pressure.

ALBUMISOL 25% (salt poor) is also available to help you manage nutritional deficiencies and severe fluid retention of advanced cirrhosis and nephrosis. Increased production now makes possible new lower prices on both products.

Albumisol®

NORMAL SERUM ALBUMIN (HUMAN)

ready for immediate blood volume replacement

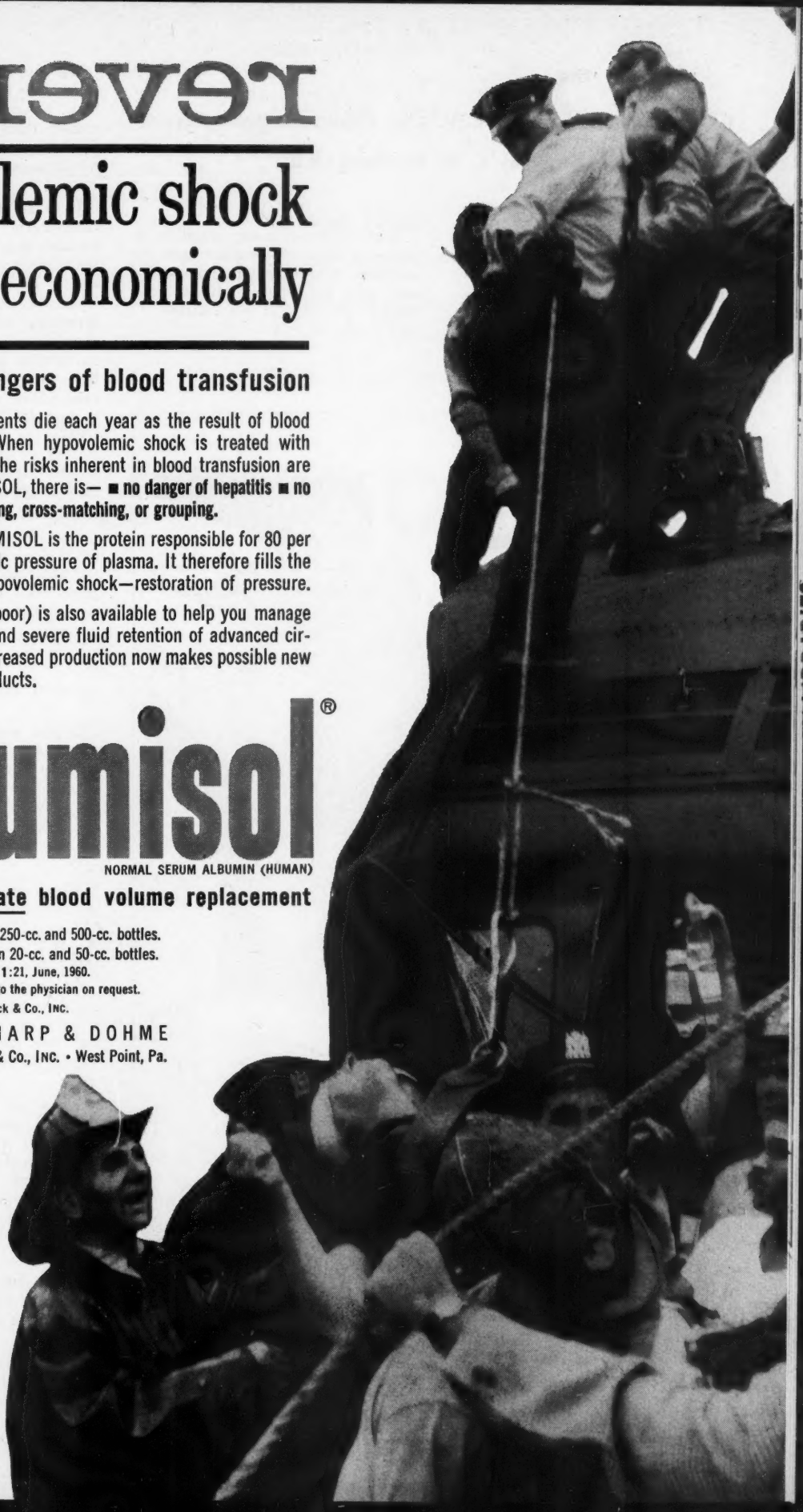
SUPPLIED: ALBUMISOL 5% in 250-cc. and 500-cc. bottles.
ALBUMISOL 25% (salt poor) in 20-cc. and 50-cc. bottles.

1. Hirsh, B. D.: Medicolegal Digest, 1:21, June, 1960.

Additional information is available to the physician on request.

ALBUMISOL is a trademark of Merck & Co., INC.

MSD MERCK SHARP & DOHME
Division of Merck & Co., INC. • West Point, Pa.



From the

consultant's notebook

by E. M. Bluestone, M.D.

Your respect for the podiatrist will increase when you examine fairly his contribution to the healing, and comfort, of sick, in addition to well, people.

•

I cannot imagine any situation in which a hospital worker can be justified, if he abandons his patient and tries to prevent others from taking his place at the bedside.

•

We will improve on our annual reports in hospitals when we learn how to make them *biographical* rather than *autobiographical.* The former point of view lends itself better to accurate historical reporting.

•

It is safer to respond to many false-alarm ambulance calls than to miss one genuine call. We cannot always expect the average citizen to be wise about such matters when he may be in doubt. Senior members of the attending staff should be as much available to the ambulance surgeon as they are to the house staff on intra-mural cases. How would you like to have a hospital orderly, however well trained in first-aid, make the decisions as to your care when you are suddenly stricken with a coronary away from home and hospital?

•

The *idee fixe* can be a dangerous psychological mood in the practice of medicine, and particularly surgery. This is a compelling reason for distributing the responsibility in such a way as to minimize its effects. We can actually judge the quality of a hospital by its consultation index.

•

If you are distributing haloes in the hospital my vote goes to the bedside nurse. She walks in where others fear to tread, reversing the old saw about fools and angels. Has anyone tried to get along without her?

•

Were you ever transported during sickness out of your home, and into a hospital located at a distance from it? Did you enjoy the ambulance ride? Was your mind at ease during the experience? If the gain to you in the long run made up for the loss (and I am not punning here) had any one taken the trouble in advance to make this clear to you?

•

When you are under pressure to "reduce costs" (as the efficiency experts call it) where do you start? What can the sick man do without? How much "economy" will satisfy the critics at any given time? What is the relation between a man's conscience and his pocketbook?

•

Sharp administrative instruments should be used with great care lest they cause pain.

•

In the care of prolonged illness, at any age, defeatism is our worst enemy.

For more information, use yellow postcard inside back cover.